

DINING AT CONTINUING CARE RETIREMENT COMMUNITIES: A SOCIAL  
INTERACTION VIEW

by

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B.S., Universiti Putra Malaysia, 2003  
M.B.A., Universiti Putra Malaysia, 2005

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Hospitality Management and Dietetics  
College of Human Ecology

KANSAS STATE UNIVERSITY  
Manhattan, Kansas

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## **Abstract**

As the number of older adults increases so does the demand for housing and personal care needs. The continuing care retirement community is unique from other senior care facilities as it provides a continuum of housing and care that caters towards an individual's need. Foodservice is often utilized to attract older adults into retirement facilities. Such service would give residents additional opportunities to socialize with service workers as well as other patrons of the restaurant. Yet, few studies have focused on the roles of food and dining service on resident's satisfaction with foodservice and their quality of life. Study 1 examined the relationships between residents' perception of individual customer orientation of service employee dimensions: technical skills, social skills, motivation, and decision-making authority, with relational benefits, satisfaction and subsequent behavioral outcomes: repurchase intention and word-of-mouth. Study 2 explored the moderating effects of resident's activity involvement and food involvement on the relationships between rapport, dining-need satisfaction and resident's quality of life. To achieve the objectives of these studies, 412 continuing care retirement community residents from five facilities completed a self-report questionnaire. Of these, 354 were used in study 1 and study 2. Findings of the structural equation modeling (Study 1) suggested that resident's perception of foodservice employee's technical skills, social skills and motivation were important determinants of confidence and social benefits that led to residents' overall satisfaction with foodservice. Satisfied resident-consumer is likely to engage in word-of-mouth and repurchase intention. Results of hierarchical multiple regressions (Study 2) revealed that perceived rapport and resident's dining-need satisfaction are positively related to resident's quality of life. This study also found that activity involvement and food involvement moderated the relationships between rapport and dining-need satisfaction with quality of life respectively. That is, the more involved resident has an improved quality of life.

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## **Dedication**

For my husband Asrar Rashid, my partner who made it all possible.

For my precious daughters Ameera Adeela and Aqeelah Husna precious gifts from Allah S.W.T.

## **Chapter 1 - Introduction**

The U.S. population aged 65 years and older should reach 71.5 million by 2026, representing 20% of the total population (American Association of Homes and Services for the Aging [AAHSA], 2008). This will have a significant impact on societal, governmental, and legislative entities as well as businesses, particularly general and senior services. In fact, the hospitality industry is moving rapidly towards senior services, offering the elderly population residential and food services (see Buzalka, 2005; Cavanaugh, 2003; King, 1999; Tindell, 2002).

The concepts of continuing care retirement communities (CCRCs) developed as a result of the increased need for housing and personal care among the elderly population. In recent years, the services offered in CCRCs have been shaped largely by the demand of current residents as well as community dwelling seniors who anticipate their own future care needs. Unlike other traditional senior care facilities, CCRCs are hospitality-oriented rather than healthcare-oriented (Lee, Shanklin, & Johnson, 2003). In addition, foodservices within CCRCs have seen similar changes, particularly as leading hospitality companies have penetrated the industry.

Food is an important component for residents in senior care facilities, especially as it represents a component in their life that residents still can control (Ball, et al., 2000; Crogan, Evans, Severtsen, & Shultz, 2004). Food affects residents' quality of life, both physical and mental health (see Ball et al., 2000; Cluskey, 2001a, 2001b; Crogan et al., 2004). Food satisfies residents' nutritional needs, while mealtimes provide residents with opportunities to socialize.

A foodservice operation is unique in that it offers both a product and service. Gustafsson, Öström, Johansson, and Mossberg (2006) explained it best with their Five Aspects Meal Model (FAMM), which introduced the multidimensionality of the dining experience: product, room, meeting, management control system, and atmosphere. In fact, Andersson and Mossberg (2004) provided empirical evidence that customers are willing to pay more for an ideal dining experience that stimulates social and intellectual needs (i.e., fine cuisine, restaurant interior, good company, service, and other guests). Further, the interpersonal relationship between the customer and the service employee greatly affects diners' satisfaction with their dining experience (e.g., Kim, 2009; Kim & Ok, 2010).

Relationship marketing literature argues that core product characteristics are no longer sufficient to achieve competitive advantage (Barnes, 1994). The marketing literature has repeatedly argued and proven empirically the importance of developing and maintaining customer relationships by satisfying current customers (e.g., Gremler & Gwinner, 2000; Guenzi & Pelloni, 2004; Gwinner, Gremler, & Bitner, 1998; Hennig-Thurau, 2004; Kim & Ok, 2010). Indeed, in foodservice, specifically in restaurants, food and beverage (the core product) suffices to satisfy customers' basic need, or hunger, but does not suffice to satisfy or delight customers in other ways (Andersson & Mossberg, 2004; Edwards & Gustafsson, 2008).

Most authors have accepted the principle of customer retention to be better business practice than constantly seeking new customers (Barnes, 1994). Developing and maintaining long-term relationships is one way to retain current customers. Studies have shown that customer-to-employee relationships lead to customer-to-firm relationships (e.g., Guenzi & Pelloni, 2004; Kim, Ok & Gwinner, 2010). Customers are willing to remain in a long-term relationship with a firm if it benefits them (Barnes, 1994).

This study proposes that the same principles found in the commercial restaurant industry apply to commercial dining services in senior care facilities. Generally, the elderly are vulnerable to deteriorating health, fewer resources, and greater need for supportive relationships (Hinson Langford, Bowsher, Maloney & Lillis, 1997), a result of the changes associated with the aging process. Thus, hypothetically, the benefit of customer-to-employee relationship is further magnified for the elderly by their need for socialization resulting from their circumstances. This relationship will not only lead to positive behavioral outcomes for the facility but also positively affects the well-being of senior residents.

### **Statement of Problems**

Much research has been devoted to the role of frontline employees in business settings (e.g., Gwinner et al. 1998; Kim, 2009; Kim & Ok, 2010; Kim et al., 2010; Susskind, Kacmar, & Borchgrevink, 2007); however, it has been left relatively unexplored in senior care facilities. In responding to the call for research, this study suggests that customer orientation of service employees and interpersonal relationships are drivers of customer satisfaction with foodservice and residents' quality of life. To the best of our knowledge, studies have yet to examine the

relationship between resident and foodservice employee in senior care settings. Overall, this study will be valuable in light of the increasing need for quality eldercare facilities.

One strategy to improve the quality of these facilities is by taking advantage of the potential of the foodservice segment in these facilities. On-site food and dining services have become increasingly important to current and potential CCRC residents. In addition to an increased demand for housing and personal care needs for older adults, foodservices within the eldercare industry have also undergone changes. The current trend in CCRCs includes full-service dining, casual dining, café or marketplace, and exhibition kitchens (Buzalka, 2005; Generali, 2010; Jhaveri, 2006). In fact, according to Jhaveri (2006) many CCRCs either have or are considering dining facilities that resemble neighborhood dining to encourage still-healthy community dwelling seniors to consider moving into their facilities. CCRCs account for approximately 38% of the eldercare's annual \$4 billion in food and beverage purchases (see Buzalka, 2005), making it a lucrative segment to be further explored.

The general belief is that moving into a senior care facility represents an individual's last move; it actually represents the beginning of a new and exciting chapter in the life of an older adult (Groger & Kinney, 2006). Providing a lifetime of care or aging in place is the philosophy for many CCRCs (Young & Brewer, 2001). Thus, the quality of care and quality of life of elderly residents is the responsibility of facilities' administrators. A socially responsible eldercare facility would ensure the well-being of their residents. Further, administrators of senior care facilities must actually satisfy their residents so as not to lose them to competitors.

## **Purpose and Objectives**

The purpose of this study is to propose and test a theoretical model consisting of the consequences of customer orientation of service employee and relational benefits on senior residents' overall satisfaction and behavioral intentions. In addition, the roles of customer-to-employee relationships and the influence of food on residents' quality of life are also explored. The specific objectives of this study are:

1. To determine CCRC residents' perceptions of customer orientation of service employees
2. To examine how customer orientation of service employee affects relational benefits



3. To assess how customer orientation of service employee affects residents' satisfaction with foodservice facilities
4. To determine how rapport and dining-need satisfaction affect residents' quality of life
5. To assess how involvement moderates residents' quality of life

In essence, this study aims to reveal the importance of customer orientation of service employee as antecedents to residents' relational benefits, satisfaction and behavioral intentions towards foodservice. The potential of resident-to-employee relationship and residents' involvement with food and activities in determining residents' quality of life, will also be determined. This study will also fill a research gap in the literature on the role of foodservice employees in CCRCs.

## **Hypotheses**

The conceptual models of this study include a total of 14 hypotheses: 10 for the first model (Figure 2.1) and 4 for the second model (Figure 2.2). In the first model, customer's perception of employee's customer orientation as antecedents to customer's perception of relational benefits, customer satisfaction and consequent behavioral intentions will be examined. In the second model, the relationships between rapport and dining-need satisfaction as antecedents of resident's quality of life will be explored. In addition, the moderating roles of activity involvement in the relationship between rapport and quality of life, and food involvement in the relationship between dining-need satisfaction and quality of life will be evaluated.

### ***First Model Hypotheses***

- H1:** Employee's technical skills have a positive effect on confidence benefits.
- H2:** Employee's decision-making authority has a positive effect on confidence benefits.
- H3:** Employee's motivation has a positive effect on confidence benefits.
- H4:** Employee's social skills have a positive effect on social benefits.
- H5:** Employee's motivation has a positive effect on social benefits.
- H6:** Employee's decision-making authority has a positive effect on social benefits.
- H7:** Confidence benefits have a positive effect on satisfaction.
- H8:** Social benefits have a positive effect on satisfaction.

**H9:** Satisfaction has a positive effect on repurchase intentions.

**H10:** Satisfaction has a positive effect on word-of-mouth communications.

### ***Second Model Hypotheses***

**H11:** Rapport has a positive effect on quality of life.

**H12:** Dining-need satisfaction has a positive effect on quality of life.

**H13:** Activity involvement moderates the relationship between rapport and quality of life.

**H14:** Food involvement moderates the relationship between dining-need satisfaction and quality of life.

### **Significance of the Study**

Many CCRCs have begun to provide a variety of dining options for residents, including full-service restaurants. The demands of residents and non-resident elderly adults who anticipate potential future needs fuel this trend. Indeed, such services would give residents additional opportunities to socialize with service workers as well as other patrons of the restaurant. Yet, less is known about the impact these dining services have on residents' satisfaction and quality of life. This study aims to bridge the gap in the literature on the potential of interpersonal relationships between service employees and elderly residents particularly as those relationships relate to their satisfaction with the dining facility and their quality of life. This study also answers the call for research that focuses on the subjective life quality aspects of living in CCRCs (Heisler, Evans, & Moen, 2004), which has often been neglected. Moreover, the financial aspect of any organization is important because finances determine longevity in business. Thus, this study also considers the managerial aspects of foodservice operations in CCRCs by focusing on consumer satisfaction and the subsequent behavioral outcomes that will ensure the success of foodservice operations.

### **Limitations of the Study**

Generally, previous studies involving elderly senior care residents have utilized the interview method (e.g., Atherly, Kane, & Smith, 2004; Cummings, 2002; Heisler et al., 2004; Krout, Oggins, & Holmes, 2000; Lengyel, Smith, Whiting, & Zello, 2004). However, this study utilized a self-report questionnaire to collect the data from CCRC residents. Previous studies

involving institutionalized elderly samples have shown that study respondents tend to respond positively for fear of repercussions (refer to Chou, Boldy, & Lee, 2001).

To ensure that the finding of this study is not undermined by biases due to data collection procedure, the researcher followed suggestion. Respondents of this study were explicitly informed that that all information gathered in this study is confidential and anonymous so that they have the freedom to divulge their true opinions and feelings. Previous study has been successful in collecting data with this method among similar sample population (e.g., Chou et al., 2001).

Furthermore, a self-report questionnaire is a far more advantageous method for data collection in this current study for a variety of reasons. First, the individual resident is a more valid source of data than an alternative source (see Spector, 2006). The only accurate source of information about internal states, including attitude, emotions, perceptions, and values can only be obtained from self-reports. Second, the survey method using a self-report questionnaire has the potential of reaching a larger sample of respondents compared to the face-to-face interview method. This is because potential respondents have the convenience of completing the questionnaire at their own leisure. This is important because an elder respondent may need more time and not feel obligated to complete the questionnaire in one sitting. This is also an effective way of controlling occasion factors that may influence measurement at a given point in time (i.e., mood) (cf., Spector, 2006).

In addition, the findings of this study may not be generalizable to the overall CCRC population. Due to limited resources, data was collected from physically and cognitively capable independent and assisted living residents in CCRCs in selected Midwestern states. As such, it is possible that certain values and opinions are shared within this group. However, it should be noted that the participants in this study had similar characteristics as participants in other CCRC studies (cf., ARAMARK Senior Living Services, n.d., Seo & Shanklin, 2005; Stacey-Konnert & Pynoos, 1992).

Finally, the cross-sectional design of the study makes it difficult to infer the causal nature of the relationships examined. Although the causal relationships developed in this study was in accordance to theoretical predictions and related literature, the interpretation of results should be done with caution.

## Definition of Terms

- **Elderly:** Refer to older adults aged 65 years and older. Can be further classified into the *young old*, the *old*, and the *oldest old*. The young old include individuals from 65 to 74, the old include individuals from 75 to 84, and the oldest old are those aged 85 and above. (AAHSA, 2008; PirkI, 2009).
- **Continuing Care Retirement Communities:** A continuum of housing including independent living, assisted living, and nursing home. In addition to providing housing options for the residents, CCRCs also provide health care, social, and additional services (Ball et al., 2000; Chao & Dwyer, 2004; Hawes, Phillips, Rose, Holan, & Sherman, 2003; Krout, Oggins, & Holmes, 2000).
- **Customer Orientation of Service Employee:** The extent to which the employee's behavior in personal interactions with customers meets those customer needs (Hennig-Thurau, 2004).
- **Relational Benefits:** Additional benefits that customers receive beyond the core service performance that can be classified into three distinct benefits: *confidence*, *social*, and *special treatment benefits* (Gwinner et al., 1998).
- **Customer Satisfaction:** The degree of overall pleasure or contentment felt by the customer, resulting from the ability of the service to fulfill the customer's desires, expectations and needs in relations to the service (Hellier, Geursen, Carr, & Rickard, 2003).
- **Repurchase Intention:** The individual's judgment about buying again a designated service from the same company, taking into account his or her current situation and likely circumstances (Hellier et al., 2003).
- **Word-of-Mouth:** Informal communication directed at other consumers about the ownership, usage, or characteristics of particular goods and services and/or their sellers (Westbrook, 1987).
- **Rapport:** A customer's perception of having an enjoyable interaction with a service provider employee, characterized by a personal connection between the two interactants (Gremler & Gwinner, 2000).
- **Consumer Involvement:** A personality characteristic of the individual toward a product or to the product categories themselves and often relates to the time investment involved

in the choice decision, and includes the social risk of using or not using a product, and the financial risk relative to one's ability to pay for the product (Bell & Marshall, 2003).

- **Activity Involvement:** Being active and embedded in a social context, through participation in a variety of activities (Gerritsen et al., 2008; Gilbert & Hirdes, 2000). Includes an ability to take advantage of opportunities for social interaction, and the ability to initiate actions that engage residents in the life of the facility (Mor et al., 1995).
- **Quality of Life:** An individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHO, 1996).
- **Gray Tsunami:** The overarching trend of aging that threatens to inundate the world's healthcare systems and sweep away today's social, political, and economic norms (Wheelwright, 2012).

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## **Chapter 2 - Review of Literature**

This chapter discusses the pertinent literature and is composed of four sections, beginning with the demographic shift towards an increasingly aging population and the resulting care and services needs of this cohort. Second, the importance of relationships from the perspectives of the facility, and resident is discussed. This is followed by relevant research on the major constructs shown in the hypothesized models. Lastly, the development of the hypotheses that will be examined in this study is explained. Based on the literature review, this chapter suggests a total of 14 hypotheses for the continuing care retirement community (CCRC) dining facilities that employ wait staff.

### **The Aging Population**

An aging population is a trend seen not only in the U.S. but is, in fact, common all over the world. In countries like Bulgaria, Germany, Greece, Italy, Japan, and Spain, the elderly outnumber children (American Association of Homes and Services for the Aging [AAHSA], 2008). Improved health, increased life expectancy, and decreased fertility rate globally, have resulted in the overarching trend of aging that threatens to inundate the world's healthcare systems and sweep away today's social, political, and economic norms or what researchers coined as the "gray tsunami" (Wheelwright, 2012). According to the 2006 American Community Survey conducted by the U.S. Census Bureau, those in the U.S. aged 65 and older is estimated at 37.3 million or 12.5% of the total population (U.S. Census Bureau, 2008). This age cohort is projected to reach 71.5 million (about 20% of the total population) by 2026 (AAHSA, 2008).

As baby boomers reach the conventional retirement age, personal care and affordable housing, including foodservice, are increasingly needed. More than 900,000 individuals reside in assisted living facilities (ALFs), 1.4 million in nursing homes, and approximately 745,000 in CCRCs in the United States (AAHSA, 2008). The Health Insurance Association of America (2002) projected that by 2020, 12 million older Americans will need long-term health care (AAHSA, 2008).

The aging phenomenon has a significant impact on societal, governmental, and legislative entities as well as businesses, particularly general and senior services. Traditionally, non-profit organizations have provided many senior services, but the need for senior living

arrangements will grow enormously (Heisler, Evans, & Moen, 2004), especially in economically modest alternatives to nursing home care like assisted living facilities (ALFs) (Cummings, 2002). Moreover, a mid-way alternative for complete independence and the rigid institutional environment of the traditional nursing home is increasingly in demand (Buzalka, 2005). CCRCs developed as a hybrid alternative from the ALF model (Buzalka, 2005).

The development of ALFs and CCRCs has changed senior living. More of the services provided by senior living facilities now consist of the hospitality component rather than the healthcare component, thus changing the dynamics of the senior living environment. Resulting in an increase in the number of contract management companies like the “Big Three” national contractors (ARAMARK, Sodexo, Compass) maintaining senior service units (Buzalka, 2005), and hospitality brands like Marriott International and Hyatt Corporation that offer living facilities for the senior niche market (Cavanaugh, 2003; Tindell, 2002).

Marriott’s assisted living brands like *Brighton Gardens*, *Marriot Maple Ridge*, *Hearthside*, and *Village Oaks*, provide services for seniors who need some help with daily activities like bathing, dressing, and medication reminders (Tindell, 2002). As a result of the high expectations from residents and competition in the industry, service providers must deliver high quality services to their residents.

### **Continuing Care Retirement Community (CCRC)**

The CCRC is a popular housing option for the elderly, and is different from other retirement options as it accommodates senior residents’ changing needs over time. CCRCs consist of a continuum of housing choices ranging from independent living to assisted living to nursing home. In addition to providing housing options for the residents, CCRCs also provide health care, social services, and additional services, which include personal care, twenty-four hour staff, housekeeping, linen services, assistance with daily living activities, medication reminders, and meals (Ball et al., 2000; Chao & Dwyer, 2004; Hawes, Phillips, Rose, Holan, & Sherman, 2003; Krout, Oggins, & Holmes, 2000).

Residents in senior living facilities, especially assisted living facilities, often require assistance with major activities of daily living including bathing, dressing, transferring, toileting, and eating (Buelow & Fee, 2000). These services, in addition to services like an onsite pharmacy, insurance billing, and banking, establish CCRC as a major attraction for elderly

residents, particularly those with increasing health-related issues and illnesses (Krout et al., 2000).

In addition to services, a variety of amenities are also available in some senior living facilities. An upscale senior living facility such as the *Classic Residence* by Hyatt has swimming pools, fitness centers, spas, tennis courts, card and game rooms, meeting rooms, and nature trails (Cavanaugh, 2003). The entrance fee for Hyatt's senior living facility ranges from \$260,000 for a one-bedroom apartment to \$800,000 for a villa, in addition to the monthly service fee that ranges from \$2,600 for a one-bedroom apartment and \$4,000 for a villa. Despite the steep pricing, Hyatt reached a 73% occupancy rate within the first year because of the upscale dining services. According to Cary Maslow, executive director of Hyatt's Classic Residence, "Food is just one component at The Glen, but it is a very important component".

Today's residents have high expectation and want to age in elegant environment with meal service that emulates fine-dining restaurants they are accustomed to patronizing (White, 2007). This results in senior living centers being comparable to high-end hotels as opposed to hospital or traditional nursing homes. As the availability of senior living facilities becomes more widespread, increased competition will cause foodservice programs to keep pace with industry trends - offering residents with unique and innovative meals. Consequently, dining services will continue to evolve. Retirement living is ever evolving and the foodservice offerings in these facilities evolve to keep the standards up.

### ***Aging in Place Philosophy***

A philosophy common in senior living facility is to encourage aging in place. Aging in place is a concept that ideally provides a spectrum of living options, medical services, and support that are customized to an individual's need (Position of the American Dietetic Association [ADA], 2000). It does not necessarily mean living in one setting for a lifetime. The CCRC encourages aging in place by having a continuum of housing options including independent living, assisted living, and nursing home or health care. The three levels of living alternatives coincide with the stages of life among the elderly: independent living for residents who can live on their own, assisted living for residents who need some help with daily care, and finally nursing home for residents who require higher levels of care (AAHSA, 2008; ADA, 2000; Cluskey, 2001b). Residents are not forced out of a facility if their physical and/or mental health

deteriorates, guaranteeing them with lifetime care (Young & Brewer, 2001). Implicit to this philosophy is the emphasis on quality of services and quality of life for each resident.

The popularity of CCRCs is due in large part to the nature of the facilities, which allows potential residents to first move into independent living and later on transition into assisted living or health care facilities as their health dictates. Additionally, it is more cost effective for seniors to move through the levels within a CCRC than it is for them to move directly from their private home to a nursing home (Cluskey, 2001b). Many facilities emphasize wellness and keeping residents as independent as possible by including services such as daily meals, transportation, housekeeping, and linen service, as well as social, cultural, and educational programs (Cluskey, 2001b; Tindell, 2002).

The objective of most CCRCs is to attract still-healthy community dwelling seniors into their independent living facilities (Buzalka, 2005). To achieve this objective many CCRCs offer an array of services and amenities that enable the community and its residents to be somewhat self-contained. Thus, residents would feel encouraged to stay within the retirement community throughout their lives once they move in because all their needs would be satisfied with available services and amenities. However, despite the facilities' efforts, most people do not consider moving into retirement communities until their late 70s and early 80s (Buzalka, 2005). In fact, the average age of residents when they first enter CCRC is 79 years, so they often require more medical care after they have tried active adult community or assisted living communities (ARAMARK Senior Living Services [ARAMARK], n.d.). Even if an elderly person moves into a CCRC, there is no guarantee that this will be their last move. An unsatisfied resident may consider other facilities that can provide them with better services. Groger and Kinney (2006) noted that moving into a senior care facility actually represents the beginning of a new and exciting chapter in the life of an elderly adult, not an individual's final move.

### ***Characteristics of Residents***

The term 'elderly' seems to refer to adults aged 65 and older by several aging organizations including Administration on Aging (AoA), American Association of Homes and Services for the Aging (AAHSA), and the US Department of Human Health and Services. The classifications for the elderly have been extended beyond the age of sixty-five to accommodate increased life expectancies for adults (Pirkl, 2009). Persons reaching age 65 have an average life

expectancy of 18.8 years (AoA, 2011). Older adults or seniors fall into three categories based on their age groups: the *young old*, the *old*, and the *oldest old*. The young old include individuals from 65 to 74, the old include individuals from 75 to 84, and the oldest old are those aged 85 and above. The average age for residents in assisted living is between 79 and 82 (Buelow & Fee, 2000), a reflection of increased life expectancies.

The process of aging is characterized by physical, physiological, and social changes (Hinson Langford, Bowsher, Maloney, & Lillis, 1997; Ryff, 1989; Williams, DeMicco, & Kotschevar, 1997). Generally, the elderly are particularly vulnerable to deteriorating health, fewer resources, and greater need for supportive relationships (Hinson Langford et al., 1997). The two most frequent and impactful life transitions are loss of functional health and loss of a spouse (Finch, Okun, Barrera, Zautra, & Reich, 1989). Thus, it is not surprising that seniors are particularly interested in interpersonal relationships, particularly with family and friends (Ryff, 1989) and seek and need social interaction (Williams et al., 1997). Jenkins, Pienta, and Horgas (2002) found more unmarried or widowed older residents in CCRCs, and they reported more physical deterioration in this group.

With regard to gender, the number and age of female residents in senior living facilities tend to be higher than males because they live longer (AoA, 2011; ARAMARK, n.d.; Buelow & Fee, 2000). In fact, more than half (63%) of senior residents in CCRCs are women (ARAMARK, n.d.). According to AoA (2011), females have an average life expectancy of 20.0 years after reaching the age of 65 compared to 17.3 years for males. In terms of education, most seniors in CCRCs are highly educated with 51% having two to four-year degrees, and 31% having a masters or higher (ARAMARK, n.d.). In fact, according to Heisler et al. (2004), elderly adults in CCRCs tend to be somewhat different from the elderly adults population at large; CCRC residents tend to be highly educated, financially secure, and female.

### **Food and Dining Services**

Older adults' decision for potential places to live is influenced by the availability of services and amenities (Groger & Kinney, 2006). On-site food and dining services have become increasingly important to current and potential CCRC residents; hence the trend towards full-service dining (Buzalka, 2005; Cavanaugh, 2003). The growth of the foodservice component in CCRCs parallels the growth of the facilities themselves (Buzalka, 2005). According to

Technomic's Senior Principal Joseph Pawlak, "CCRCs account for about \$1.5 billion of eldercare's annual \$4 billion in food and beverage purchases" (Buzalka, 2005, p. 42), representing a substantial market segment within the senior care industry.

### ***Food as a Marketing Tool***

Aging is characterized by the process of change that includes physiological changes, as well as social and economic changes, and changes in the outlook of food (Williams et al., 1997). Food is important for residents in long term care facilities, particularly because it represents one part of their lives that residents still control (Ball et al., 2000; Crogan, Evans, Severtsen & Shultz, 2004). By offering meals in the facilities, care providers can better oversee residents' nutrition and health care. Cluskey (2001b) noted that a large number of older adults (older than 80) could live independently when three meals were provided by the facility. "Successful aging" among residents involves providing food (ADA, 2000; Cluskey, 2001b) to help residents stay healthy and be more independent. Thus, food becomes a marketing tool for many CCRCs, and residents are encouraged to consume the meals provided (Cluskey, 2001b).

A study conducted among community dwelling seniors found nutritional quality was most important in selecting a place to eat (Becker-Suttle, Weaver, & Crawford-Welch, 1994). This is not surprising because the elderly emphasize health (Buzalka, 2005; Ryff, 1989). Furthermore, the nutritional needs of older adults are crucial to their physical and mental health and their quality of life (Ball et al., 2000; Chao & Dwyer, 2004; Crogan et al., 2004). Buelow and Fee (2000) suggested improvements in the areas of food quality, time flexibility, and seating flexibility. In fact, in addition to more choices, residents in CCRCs expect flexibility in time and scheduling of services (Seo & Shanklin, 2005).

A variety of foodservice models are available for elders, ranging from buffets to restaurants, home style service, or even medical models (Chao & Dwyer, 2004; Seo & Shanklin, 2005). Each service theme emphasizes different aspects of food and nutrition. For example, a restaurant themed service would emphasize the social aspects of dining through menu selection, generous portions, attractive surroundings, courteous table service, and a social atmosphere. Health needs of individual residents who require special diets and assistance with eating might be neglected in this service model, but a medical or health themed food service model would respond to this need.

Senior living communities offer an array of venue options, including café or marketplace, bistro or casual restaurants, open or exhibition kitchens, and fine dining restaurants (Buzalka, 2005; Generali, 2010; Jhaveri, 2006). According to Jhaveri (2006), the popularity of these venues generally follows the same sequence; the most popular is the marketplace, followed by casual dining, and then fine dining. In fact, the percentage ratios have remained relatively constant: 65:25:10 in communities with all three options, and 70:30 in communities that feature only marketplace and fine dining. The future of foodservice in living facilities for the elderly would be a hybrid approach that combines both health and social aspects of a meal, in addition to being adaptable to residents' need.

### ***Food as a Socialization Tool***

In addition to providing nourishment, mealtimes also serve as an opportunity for socialization because eating in a collective dining area allows residents to socialize with one another, as well as have social contact with the meal server (Cluskey, 2001b). In fact, many seniors have had wonderful relationships with the foodservice staff (Cluskey, 2001b). Mealtimes represent family life as many relate it to foods served for celebrations and everyday meals (Crogan et al., 2004).

The benefit of offering meals to senior residents is so well recognized that most (98.3%) assisted living facilities provide three meals a day (Hawes et al., 2003). Cluskey (2001a) found that most independent living residents (73%) consume meals in the collective dining room, with 17% indicating that they eat out one or more times per week. Additionally, after moving into a retirement center, more than half (63%) of respondents said that they ate more at the center because they enjoyed the social aspect of dining, while only 2-3% of all respondents reported that they ate alone.

Meals may be delivered in a variety of settings, from buffets to full service like that found in restaurants (Seo & Shanklin, 2005). An attractive array of services and amenities provide opportunities for socializing, amusement, and personal development, which is the key to satisfying current residents and attracting future residents (Buzalka, 2005). Residents in senior living facilities crave a place to socialize; a dining venue with the right ambience and set menu could provide residents with the perfect opportunity to socialize. To encourage still-healthy community dwelling seniors to consider moving into their facilities, many CCRCs either have or

are considering dining facilities that resemble neighborhood dining (Jhaveri, 2006). Programs and services that allow the outside community to interact with residents also help create an environment that is vibrant, dynamic, and lively, thus, providing the facility with a competitive advantage over other facilities.

Well-developed programs and services benefit both residents and the facilities themselves (Jhaveri, 2006). First, senior residents prefer to live in an environment with intergenerational experiences to keep from feeling isolated from the world at large. This would surely have an impact on residents' quality of life. Second, such services and amenities attract not just current residents but also the general public, making it a wonderful marketing tool for future residents. Third, these services provide potential additional revenues for the organization. In most cases, the quality of onsite dining operations is an important criterion to convince healthy seniors to consider relinquishing their homes and moving into retirement communities (Buzalka, 2005; Cavanaugh, 2003).

The aging phenomenon has pushed the foodservice management industry into becoming more involved in senior living services (King, 1999). In fact, all three of the Big Three national contractors (ARAMARK, Sodexo, and Compass) maintain senior service units with an emphasis on the CCRC sector (Buzalka, 2005). ARAMARK, for example, delivers dining and facility management solutions for senior living (ARAMARK, n.d.). Quality is the main reason many eldercare facilities are outsourcing food and service (Buzalka, 2005; Williams, 2001).

### **Importance of Relationships**

It is often presumed that relationship marketing would lead to superior economics of customer retention and thus creates a competitive advantage to the firm (Sheth & Parvatiyar, 1995). However, not all businesses should practice relationship marketing. Senior living facilities might benefit from relationship marketing because of increased vulnerability associated with the aging process, which will be discussed further in the following sections.

### ***Firm's Perspective***

Maintaining long-term relationship with customers is important for firms because retaining current customers costs less than attracting new customers (Zeithaml, Berry, & Parasuraman, 1996). Businesses often rely on relationships to ensure their survival (Gremler &



Gwinner, 2000; Morgan & Hunt, 1994). Customers may build interpersonal relationships with the operation's employees or other customers (Guenzi & Pelloni, 2004) and in turn, such relationships may influence judgments about the service (Gremler & Gwinner, 2000). In fact, the interaction between service provider and customer is an important determinant of customer satisfaction with services (Bitner et al., 1997; Fisk, Brown & Bitner, 1993). According to Zeithaml et al. (1985), service firms often choose and train their customer-contact personnel to interact well with customers. Additionally, some service firms also emphasize some degree of sensitivity to customer needs or customer orientation to reduce problems related to the uniqueness of services.

Relationships between the customer and the employee can contribute both positively and negatively to customer-to-firm relationships (Guenzi & Pelloni, 2004; Kim, Ok, & Gwinner, 2010). Positive contributions of customer-to-employee relationship to a firm's success include overall customer satisfaction and attitudinal and behavioral loyalty to the firm (e.g., Gremler & Gwinner, 2000; Guenzi & Pelloni, 2004). A relationship with a service provider makes customers more aware of the provider's role in service delivery; thus, customers are more likely to receive the outcome that they seek (Bitner et al., 1997).

Alternatively, the negative contribution of relationships with employees includes customer's increase willingness to follow the employee when they leave a firm (Guenzi & Pelloni, 2004). Further, for service in which interactions between customers are possible, customer-to-customer relationships can also lead to loyalty towards the other customer. Despite this, the literature supports the importance of relationships to service firms. Although a business often does not have direct control over the interpersonal relationships between customers, employee-to-customer relationships can be somewhat controlled or shaped by the business through employee training.

Among the qualities that help build relationships with residents are kindness, respect, consistency, cheerfulness, and gentle assertiveness, all important qualities not only for nursing assistants in ALFs (Buelow & Fee, 2000) but also for service employees. Senior care facilities may encourage their employees to develop or increase their interpersonal and communication skills by incorporating these elements in their employee training programs.

### ***Resident's Perspective***

According to McGilton (2002), people are social beings, and interactions with others provide support, comfort, love, and affection. All that makes life worth living. Ryff's (1989) study emphasized the importance of the interpersonal dimension or "others' orientation" (being a caring and compassionate person and having good relationships with others) for older and middle-aged adults, although, at the time, other studies revealed other positive function indicators. According to Kane (2001), relationships are the key to living, whether the relationship is love, friendship, or even rivalry with family, friends, and other residents. These human relationships and social contact with others are crucial to the quality of life for seniors, especially as they experience more stressful life events like the death of a spouse, deteriorating health, retirement, or relocation. According to Gilbert and Hirdes (2000), strong social support can help the elderly adapt to these stresses.

The elderly also generally have more health problems, fewer resources, and more need for supportive relationships than younger people, so much so that at times, the main purpose of moving to senior care facilities is to be surrounded by people (Ball et al., 2000). Cluskey (2001b) reported senior residents build up wonderful relationships with the dining room staff. Positive relationships between service employees and residents, as well as among residents, increase residents' satisfaction and enhance their engagement in positive behaviors that ultimately improve their well-being.

### **Characteristics of Services**

During the 1970s, researchers began a debate on whether service marketing was a subset of marketing that differs from goods marketing (Fisk, Brown & Bitner, 1993; Rathmel, 1966). Intangibility, inseparability, heterogeneity, and perishability are characteristics unique to services (Fisk et al., 1993; Zeithaml, Parasuraman & Berry, 1985), often used in examining buyer behavior and developing market strategies (Wolak, Kalafatis & Harris, 1998). Marketing scholars have generally accepted these characteristics; however, some studies show that customers perceive different characteristics of services (Hartman & Lindgren, 1993; Wolak et al., 1998).

The following sections discuss the four characteristics in more detail, including ways in which consumers considers these characteristics, as well as arguments on the legitimacy of the four characteristics of service.

### ***Intangibility***

*Intangibility* is the fundamental difference separating services from goods (Zeithaml et al., 1985). Unlike tangible goods, services are performances or acts, which cannot be touched, felt, or tasted. As such, services are essentially experiential. Customers reflect on the tangibility of services or products to evaluate risk in making a purchase (Hartman & Lindgren, 1993; Wolak et al., 1998). One strategy with which service firms might make their services more tangible by creating an image for the service, using such things as uniforms or outward appearance of personnel, facility design, or servicescape (Zeithaml et al., 1985).

Tangibility in the service industry can range from completely intangible to semi-tangible to completely tangible (Zeithaml, Bitner, & Gremler, 2006). The foodservice industry lies in the middle of the product-to-service continuum because it involves both services and tangible goods (food or meal). In Wolak et al. (1998), respondents considered a restaurant meal to have equal parts of product and service.

### ***Inseparability***

Risk also influences a customer's decision to patronize a service. Unlike tangible goods, a service once patronized cannot be returned. *Inseparability* involves the simultaneous production and consumption of services (Zeithaml et al., 1985). In most cases, the time it takes for the service and product to be produced and consumed is short (e.g., food ordered at a restaurant). This inseparability encourages interdepartmental co-production. For example, in a restaurant, the front of the house must work closely with the back of the house to complete a service.

According to Bitner, Faranda, Hubbert, and Zeithaml (1997), customers are vital in creating service and their own satisfaction. Customers are usually part of the production and consumption process, and they can provide immediate feedback to the service provider on the service that they are receiving. The level of customer participation, nevertheless, varies across services.

### ***Heterogeneity***

*Heterogeneity* refers to the differences in the level of service different customers may receive. Service providers cannot provide the same performance all the time; there is variability from producer to producer, customer to customer, and day to day (Zeithaml et al., 1985). Even when the same service employee performs, consistency may still falter.

Hartman and Lindgren (1993) suggested high quality customer contact personnel are important in controlling customers' perceived risk associated with variability in services. Although this characteristic, which is unique to services, may be problematic (Zeithaml et al., 1985), heterogeneity or variability in services can be marketed as something positive. Rather than limiting variability, some customers may value heterogeneity in the form of customization (Hartman & Lindgren, 1993; Wolak et al., 1998). Indeed, findings in Zeithaml et al. (1985) suggest that problems indicated in scholarly literature were not necessarily perceived as problems by service firms.

### ***Perishability***

*Perishability* is characterized by the inability of services to be saved or stored for use at a different time. This characteristic is often a concern for the service provider but not for customers because if a service is not purchased or patronized for the day, it is gone. A hotel room left vacant for the night, an unseated table in a restaurant, and an airline seat not purchased, are all perishable items wasted and revenues lost.

### ***Summary***

Wolak et al. (1998) reported disagreement over the fourth characteristic of services. Their study found respondents used three characteristics to differentiate services from products: namely, tangibility, heterogeneity, and inseparability. Perishability of services does not affect customers as much as service providers. However, all four characteristics of service are widely accepted by scholars and marketers.

A restaurant meal is essentially experiential, as are any foods and beverages. Customers simultaneously produce and consume services, providing them with a natural opportunity to develop a relationship with the service employees. In the CCRC setting, this opportunity is further magnified by resident's frequent interaction with the same service employee. Thus,

CCRCs provide an excellent opportunity for research on interpersonal relationships between customer and employee on a scale different from the relationship that may develop in other commercial settings.

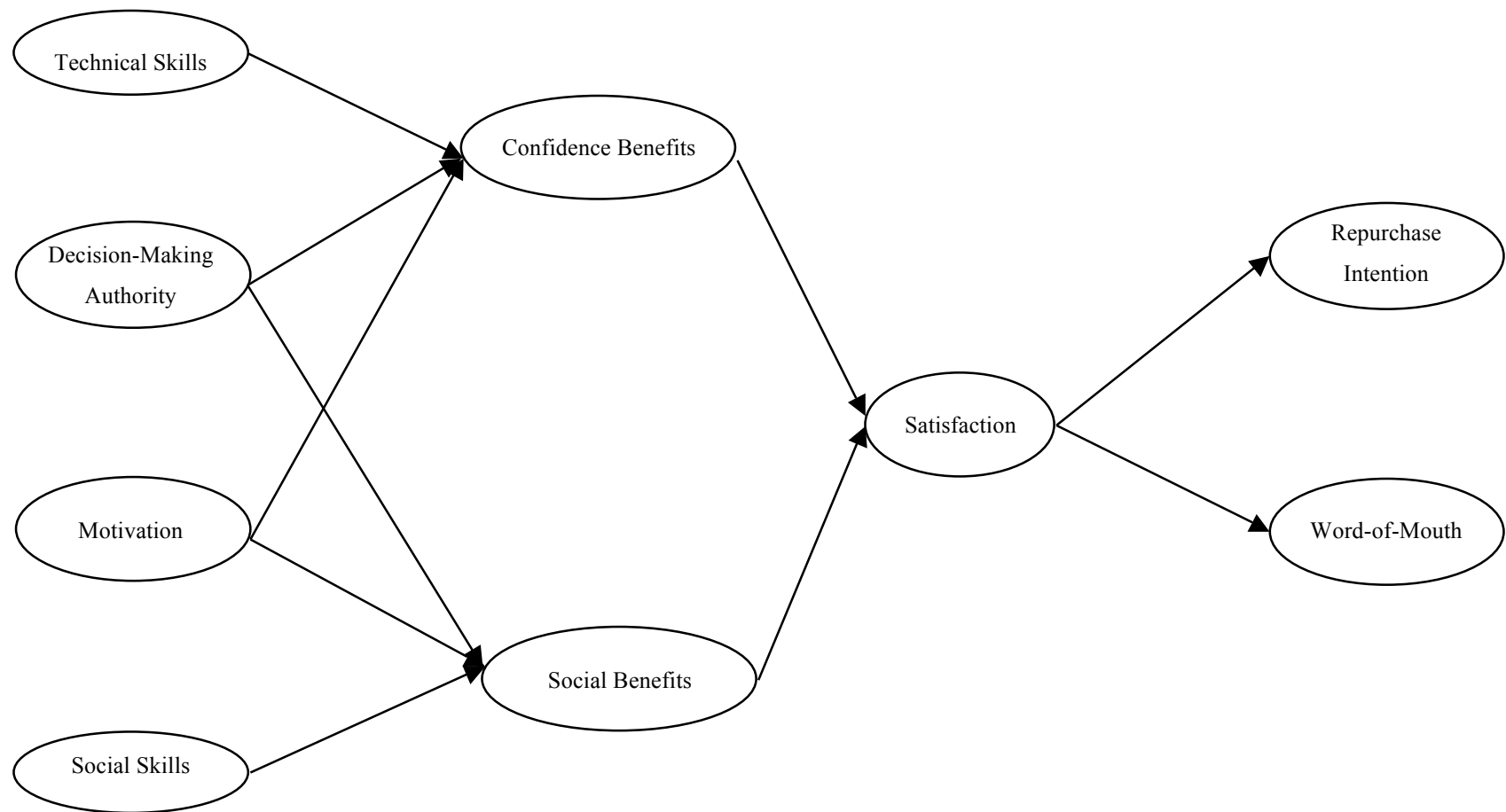
### **Constructs of the Conceptual Models**

The hypothesized conceptual models for studies 1 and 2 are presented in figures 2.1 and 2.2 respectively. The following sections will discuss the review of literature and subsequent hypotheses of the studies as they appear in the conceptual models, flowing from the left to the right, beginning with Study 1 and followed by Study 2.

#### **Study 1**

The first model of this study examines the relationships among the constructs of customer orientation of service employees (COSE), relational benefits, and their effects on residents' satisfaction with foodservice facility and the subsequent behavioral intentions. This model focuses on the services marketing aspects of dining, and is vital for the success of the dining establishments in CCRCs. As previously mentioned many CCRCs either have or are considering developing dining services because they provide a potential for additional revenues and is an excellent marketing tool for future and current residents of the facilities. However, the benefit of such an undertaking is still unclear. This study attempts to shed light on residents' perceptions of service employees' customer orientation and how it may impact residents' perceptions of confidence and social benefits, as well as their satisfaction and behavioral intentions towards dining.

**Figure 2.1** Proposed Conceptual Model for Study 1



### ***Customer Orientation of Service Employees (COSE)***

Customer orientation (CO) is central to the marketing concept and philosophy (Donavan & Hocutt, 2001; Hennig-Thurau & Thurau, 2003; Morgan, 1996; Saxe & Weitz, 1982) and relationship marketing (Hennig-Thurau & Thurau, 2003). According to Saxe and Weitz (1982), “customer-oriented selling can be viewed as the practice of the marketing concept at the level of the individual salesperson and customer” (p. 343). Practitioners and scholars have seen its potential benefits: customer satisfaction (Donavan & Hocutt, 2001; Homburg, Hoyer, & Bornemann, 2009), willingness to pay (Homburg et al., 2009), profitability (Homburg, Hoyer, & Fassnacht, 2002), customer commitment (Donavan & Hocutt, 2001; Hennig-Thurau, 2004), positive word of mouth communication (Hennig-Thurau, 2004), and others. Thus, it is not surprising that studies on CO have been conducted at both organizational (e.g., Brady & Cronin, 2001; Homburg et al., 2002; Kennedy, Goolsby, & Arnould, 2003) and individual (e.g., Donovan, Brown, & Mowen, 2004; Hennig-Thurau, 2004; Homburg et al., 2009) levels.

Organizational studies of CO have often conceptualized CO as an organization’s *culture* whereas individual level studies conceptualized the construct as the employee’s *behavior* or *personal tendency*. For example, Deshpande, Farley, and Webster (1993) initially defined CO as “the set of beliefs that puts customer’s interest first” (p. 67). CO is an important indicator of performance for both organizations and employees (Kelley, 1992).

A customer oriented service operation often relies on the service personnel to implement its CO strategy. Thus, the success of a service operation is typically determined by the behavior of service employees, because the employee is usually the primary representative of the operation. Many studies have focused on employee CO because of their importance in executing or fulfilling the operation’s CO strategy. Thus, various descriptions or definitions of employee CO exist in the literature. Initially, Saxe and Weitz (1982) defined CO as the practice of the marketing concept at the individual level. Later, Brown, Mowen, Donovan, and Licata (2002) described CO as a personality variable that reflects an employee’s tendency or predisposition to meet customer needs, which comprise two dimensions: the needs dimension and the enjoyment dimension. Donovan and Hocutt (2001) concurred that an employee with the personality traits common to customer orientation will fit the service setting better than someone without the traits.

The practice of CO by service personnel is also known as customer orientation of service employee (COSE). COSE is defined as “the behavior of service employees when serving the needs and wishes of existing and prospect customers” (Hennig-Thurau & Thurau, 2003, p. 27). Hennig-Thurau (2004) defined COSE as “the extent to which the employee’s behavior in personal interactions with customers meets those customer needs” (p. 462). Satisfying customer needs is ultimately the focus of CO and COSE. In fact, research shows that an employee’s display of CO affects customer satisfaction (e.g., Donovan & Hocutt, 2001; Hennig-Thurau, 2004; Kim, 2009; Kim & OK, 2010; Susskind, Kacmar, & Borchgrevink, 2007).

Donavan and Hocutt (2001) found higher levels of COSE (as perceived by customers) correlates to higher levels of customer satisfaction and customer commitment. Additionally, the behavior of service employees affected customers’ judgments of the quality of service (Hennig-Thurau, 2004). In fact, employees who have the motivation and skills (both technical and social) are more likely to influence customer satisfaction and commitment to build stable relationships. Brady and Cronin (2001) found that customers of customer-oriented firms consistently perceive higher quality and thus increase their loyalty, repurchase intentions, and participation in positive word-of-mouth. Meeting customer needs is the main objective of COSE (Brown et al., 2002; Hennig-Thurau, 2004), and it is crucial to relationship marketing (Hennig-Thurau & Thurau, 2003). According to the research, more emphasis should be placed on recruiting employees with a positive disposition towards meeting customer needs, while at the same time training new and existing employees (Brown et al., 2002; Hennig-Thurau, 2004).

Past studies have evaluated employee customer orientation from the perspectives of customers and employees or supervisors. In a service encounter, the interpersonal element of the interaction between employee and customer is usually evaluated from the customer’s point of view (Bitner, Booms, & Tetreault, 1990). Furthermore, several researchers have suggested that COSE should be determined from the customer’s perspective, not the employee’s perspective (cf. Kelley, 1992; Donovan & Hocutt, 2001). Thus, this study will use customer evaluation of service employee’s customer orientation behavior because the study will examine the relationship between wait staff’s CO, relational benefits and customer’s satisfaction, and behavioral outcomes (repurchase intention, word-of-mouth communication).



### ***Dimensions of COSE***

COSE consists of interrelated constructs of employee customer-oriented skills, employee motivation, and employee self-perceived decision-making authority (Hennig-Thurau & Thurau, 2003; Hennig-Thurau, 2004). Employee customer-oriented skills are further classified into technical skills and social skills (Hennig-Thurau, 2004). According to this conceptualization of COSE, technical skills refer to knowledge and skills needed to fulfill customer needs during encounter. A foodservice employee's technical skills would include knowledge of the menu and ingredients, skills in serving customers, and managing multiple tables (Kim, 2009). Social skill is the ability to take on the customer's cognitive, visual, and emotional perspective during interactions (Hennig-Thurau, 2004). A service employee must understand customers' verbal and non-verbal cues to fulfill their needs in a proper and timely manner.

Employee motivation refers to the desire of service employees to behave in a customer-oriented manner; it has three elements:

1. "a positive valence of customer-oriented behavior and the consequences associated with such behavior on the part of the employee;
2. the employee's self-perception of being able to behave in a customer-oriented way;
3. and his or her expectations of reaching a desired outcome through engaging in such behavior (e.g. happy customers, rewards from the employer)" (Hennig-Thurau, 2004).

Motivation is important because even the most skilled and knowledgeable employee will not attempt to satisfy customer's needs and wishes without the motivation to do so.

Finally, self-perceived decision-making authority is a subjective concept related to the more objective concept of empowerment (Hennig-Thurau, 2004). It refers to "the extent to which service employees feel authorized to decide on issues that concern customers' interests and needs" (p. 463). An employee must possess all four dimensions to perform in a customer-oriented manner. Just as for motivation, decision-making authority transforms employee intentions and skills into actual behavior.

### ***Relational Benefits***

The benefits of customer loyalty to a firm have previously been researched; however, less attention has been given to the benefits of being loyal to a service provider from the customer's perspective (Barnes, 1994, 2003; Sheth & Parvatiyar, 1995). According to Barnes (2003) customers do “establish close meaningful relationship with many companies and brand” (p. 179). The relationship that develops between the customer and service provider have similar characteristics to emotional attachment to friends, family members and colleagues (Barnes, 2003; Dwyer, Schurr, & Oh, 1987; Goodwin, 1996).

To develop enduring relationships that can withstand competition from more convenient and efficient competitors, service providers must create emotional value for the customers (Barnes, 2003). Shared history, values, goals, interests, beliefs; sense of commitment, reliance, social support, intimacy, interest, respect, and trust are some of the example of values that would contribute towards emotional loyalty and lasting relationships. To maintain a relationship, both parties in the relationship must benefit from it (Barnes, 1994; Gwinner, Gremler, & Bitner, 1998).

Customers who have developed a relationship with a service provider expect to receive satisfactory delivery of core service. However, customers are likely to receive other benefits as a result of having cultivated enduring relationships with the service provider. Relational benefits are additional benefits that customers receive beyond the core: *confidence*, *social*, and *special treatment* (Gwinner et al., 1998). Confidence benefits refer to the “perceptions of reduced anxiety and comfort in knowing what to expect in the service encounter” (Hennig-Thurau, Gwinner, & Gremler, 2002, p. 234). Social benefits refer to the emotional element of the relationship, characterized by personal recognition of customers by employees and friendship (Gwinner et al., 1998; Hennig-Thurau et al., 2002). Special treatment benefits are price breaks, faster service, or individualized additional services (Hennig-Thurau et al., 2002).

Of the three, consumers rated confidence benefits as consistently more important, followed by social and special treatment benefits. According to Gwinner et al. (1998), confidence benefit is important to consumers; they have reduced anxiety and less perception of risk because they know what to expect from the service relationship and have increased faith in the trustworthiness of the service provider. In fact, Kinard and Capella (2006) found confidence benefits influenced consumer loyalty, word-of-mouth, and satisfaction levels.

COSE is an important antecedent of relational benefits (Kim, 2009). Moreover, relational benefits (particularly confidence benefits and special treatment benefits) affect customer satisfaction through favorable inequity. Additionally, satisfied customers are more likely to have higher repurchase intention. COSE possibly leads to relational benefits as a result of the development of a relationship.

Social interaction is important for older adults, and studies have shown that mealtime often offers dual benefits improving their quality of life through both nutrition and socialization (e.g., ADA, 2000; Cluskey, 2001a). The development of a stable relationship between customer and foodservice employee in a CCRC could affect a customer's perception of social benefits thus leading to customer satisfaction. In addition, the type of service also affects a customer's perception of relational benefits. Customers of high contact, customized service (i.e., hairdresser/barber) perceived greater relational benefits than customers of moderate contact, standardized service (i.e., fast food) (Kinard & Capella, 2006).

In the CCRC context, residents are expected to receive relational benefits in the form of confidence and social benefits. Service providers that make an effort to learn about the customers and develop friendships with them; in addition to attenuating customers' perceptions of risk and anxiety will surely be rewarded. The payback for firms that are successful in developing and maintaining meaningful relationships with the customers through emotional value is considerable. They can expect repeat business, higher share of wallet, and much more longevity in the relationship and willingness to advocate the business (cf. Barnes, 2003).

### ***Consequences of Customer Orientation of Service Employees***

Providing quality service and satisfying residents are essential for a successful CCRC operation. Thus, it is not surprising that the management of many CCRCs is benchmarked against the hospitality industry as opposed to the healthcare industry. Quality of food, dining environment, and wait staff are factors that must be considered in providing a dining experience. Offering good food is central to any successful foodservice operation; however, empirical evidence suggests that customers are willing to pay more for a good dining environment and quality service (Andersson & Mossberg, 2004). A good wait staff can make an ordinary meal memorable for the customer and thus may affect customer's satisfaction. The importance of the

wait staff in the customer-employee interaction has been shown in previous studies (e.g., Kim, 2009; Pettijohn, Pettijohn, & Taylor, 2004).

Customer-oriented service personnel are highly motivated, with technical skills, social skills, and perceived decision-making authority to fulfill the needs and wishes of customers (Hennig-Thurau & Thurau, 2003; Hennig-Thurau, 2004). Such an employee will deliver quality service and, as a result, enhance customer's satisfaction. Pettijohn et al. (2004) administered a study among restaurant wait staff and found that positive relationships exist between employee customer orientation and sales skills. Motivation is absolutely necessary for employees' technical and social skills to be expressed through behavior. Perceived decision-making authority is expected to have a positive influence on employee's motivation to behave in a customer oriented manner.

A service employee with the motivation, technical knowledge, and decision-making authority can assist the customer with the menu, provide suggestions, and fulfill specific requests from customers. Such an employee will provide quality service that would reduce customers' perceptions of anxiety and risk; knowing what to expect from the service relationship and have increased faith in the trustworthiness of the service provider (Gwinner et al., 1998). In other words, customers have increased confidence benefits. Kim (2009) found COSE as an important antecedent to relational benefits. In line with this, the following is hypothesized:

**H1:** Employee's technical skills have a positive effect on confidence benefit.

**H2:** Employee's decision-making authority has a positive effect on confidence benefit.

**H3:** Employee's motivation has a positive effect on confidence benefit.

Hennig-Thurau (2004) found service employee's social skills and motivation to fulfill customer needs strongly influence satisfaction and commitment, leading to the development of stable relationships with customers. According to the author, an employee must possess all dimensions of COSE (motivation, perceived authority, and skills) in order to behave in a CO manner. This study postulates that service employees who possess the motivation, social skills, and decision-making authority are likely to recognize and be familiar with the consumer. In addition, a customer-oriented employee is more likely to build a relationship with the customer.

Social interaction is an important activity for older adults, and studies have shown that mealtime often offers dual benefits improving their quality of life through nutrition and

socialization (e.g., ADA, 2000; Cluskey, 2001a). Stacey-Konnert and Pynoos (1992) observed that most (approximately 75%) CCRC residents had, on average, more social interactions within the community; they socialized with three non-relatives in the CCRC but only one non-relative outside the CCRC. Additionally, residents often report a variety of social activities.

Developing a stable relationship between the customer and the foodservice employee in CCRC, derived from employee's social skill, motivation, and decision-making authority could affect a customer's perception of social benefits. Thus, the following three hypotheses are proposed:

**H4:** Employee social skills have a positive effect on social benefit.

**H5:** Employee motivation has a positive effect on social benefit.

**H6:** Employee decision-making authority has a positive effect on social benefit.

### ***Customer Satisfaction***

Customer satisfaction is an important concept in marketing and so has been studied extensively over the years. The proliferation of studies in customer satisfaction stems from its profit generating potential; however, consensus on the concept itself is yet to be reached (cf. Yi, 1990; Szymanski & Henard, 2001). Customer satisfaction studies can be helpful if they bridge the gap between strategies to improve service attributes and return visits or repurchase intentions, thus ensuring financial success (Dube, Renaghan, & Miller, 1994). A high level of customer satisfaction does not necessarily guarantee financial success; the trick is to balance cost and benefit associated with strategies used to fine-tune or improve service or product and thus meet the needs of the target market.

Customer satisfaction is often used as a predictor of revisit intention to a foodservice establishment (Dube et al., 1994). Review of previous research in marketing and specifically within the foodservice industry shows that satisfaction leads to repeat custom (Anderson & Sullivan, 1993; Cronin & Taylor, 1992; Johns & Pine, 2002). Although a satisfied customer is not guaranteed to return, a discontented customer will almost certainly not come back. However, a customer may consider giving a foodservice establishment another chance even after a service failure, provided the customer already had a relationship with the business (DeWitt & Brady, 2003).

Customer satisfaction has been the central construct in many studies; it leads to loyalty intentions to the firm (Guenzi & Pelloni, 2004) and repeat purchase intentions (Dube et al., 1994; Kim, 2009; Kim & Ok, 2010, Szymanski & Henard, 2001). Cronin, Brady, and Hult (2000), simultaneously examined the effects of service quality, value, and satisfaction on consumer behavioral intentions, finding all three were directly related to behavioral intentions (including positive word of mouth, recommendation to other consumers, loyalty or repurchase, and a willingness to spend more with the company).

This construct has also been central in studies of senior care settings (e.g., Atherly, Kane, & Smith, 2004; Buelow & Fee, 2000; Chou, Boldy, & Lee, 2001; Lengyel, Smith, Whiting, & Zello, 2004; Young & Brewer, 2001). These studies have covered a variety of subjects from resident satisfaction with facilities and services (e.g., Buelow & Fee, 2000; Chou et al., 2001; Young & Brewer, 2001) to the development and evaluation of measurement tools for senior care facilities (e.g., Atherly et al., 2004; Lengyel et al., 2004).

Among the antecedents of customer satisfaction are expectation, disconfirmation of expectations, performance, affect, and equity (Szymanski & Henard, 2001). The authors found equity and disconfirmation had the strongest effects on satisfaction. In the current study, customer satisfaction is considered as a one-dimensional construct, in which satisfaction and dissatisfaction are on a single continuum. The customer satisfaction definition used in this study is the “degree of overall pleasure or contentment felt by the customer, resulting from the ability of the service to fulfill the customer’s desires, expectations and needs in relations to the service” (Hellier, Geursen, Carr, & Rickard, 2003; p. 1765). The measure of customer satisfaction will be limited to overall satisfaction of customer with foodservice.

### ***Consequences of Relational Benefits***

To achieve customer satisfaction, service provider must at least fulfill the functional performance of the service. Relational benefits are additional benefits received as a result of long-term relationship above and beyond the core service. Any benefits received beyond the functional performance of service will very likely increase consumer satisfaction. As such, it is postulated that relational benefits, particularly confidence and social benefits, would lead to satisfaction. Confidence benefits in the form of less risk perception and more confidence in the trustworthiness of the service provider is expected to positively affect consumer satisfaction.

Social benefits in the form of personal recognition, familiarity, and friendship built through interaction with a service employee will likely affect consumer satisfaction. Although social benefits emphasize on relationships rather than on performance, social benefits can be expected to have a positive impact on customer satisfaction. The interaction between employee and customer is central to customer's satisfaction in many services (Bitner et al., 1997; Fisk et al., 1993), and social benefits are desired by elderly residents (Kane, 2001; McGilton, 2002; Ryff, 1989), as such it is expected that social benefits will have a positive relationship with customer satisfaction. Thus, the following hypotheses are advanced:

**H7:** Confidence benefits have a positive effect on satisfaction.

**H8:** Social benefits have a positive effect on satisfaction.

### ***Behavioral Intentions***

Theory suggests that increasing customer retention or reducing customer defection is crucial to generating profits (Zeithaml et al., 1996). Favorable behavioral intentions are associated with a service providers' ability to get the customers to 1) say positive things about them, 2) recommend them to other consumers, 3) remain loyal to them (i.e., repurchase from them), 4) spend more with the company, and 5) pay price premiums. In this study, two behavioral intentions will be assessed: repeat purchase intentions and positive word-of-mouth (WOM).

#### ***Repeat Purchase Intention***

Repeat purchase intention is an important indicator of a business's success, at times more useful than customer satisfaction (Dube et al., 1994). Repeatedly, empirical studies support the relationship between customer satisfaction and repurchase intention (Anderson & Sullivan, 1993; Cronin & Taylor, 1992; Cronin et al., 2000; Fornell, 1992; Szymanski & Henard, 2001). This suggests that a firm is likely to retain customers as their satisfaction increases.

As previously mentioned, consumers may show their loyalty to a service provider through repurchasing (Zeithaml et al., 1996). Repeat purchase and loyalty are often mentioned simultaneously; according to Dick and Basu (1994), implicit in research, brand loyalty helps generate repeat business. Maintaining long-term relationships with customers is economically more advantageous than constantly seeking new customers (Zeithaml, et al., 1996; Sheth & Parvatiyar, 1995).

Other than a focus on satisfaction, another strategy to prevent or reduce the rate of customer defection is by manipulating consumer perceptions of switching barriers. Jones, Mothersbaugh, and Beatty (2000) suggested developing interpersonal relationships, imposing switching costs, and creating attractive alternatives as ways to keep customers from leaving. High switching barriers decrease the influence of core-service satisfaction on repurchase intentions.

Recently this relationship has been questioned, despite repeated findings confirming the relationship between customer satisfaction and repeat purchase intentions. Hellier, et al. (2003) found no direct positive relationship between customer satisfaction and repurchase intentions. Thus, the link between customer satisfaction and repurchase intention may be more complex than previously thought (Hennig Thureau & Klee, 1997; Yi & La, 2004). Furthermore, according to Mittal and Kamakura (2001) “the functional form relating satisfaction to repurchase intention differs from the functional form relating satisfaction to repurchase behavior” (p. 140). Thus, it would be misleading to predict repurchase behavior using repurchase intention alone.

However, mixed findings on repurchase intentions could be explained by differing methods used in the studies (cf. Szymanski & Henard, 2001). These authors found that using multi-item versus single-item measures of customer satisfaction, using student versus non-student samples, and the type of offering (product versus service) affected the results. However, many satisfaction studies have used repurchase intention as a criterion variable because it is an efficient way of collecting data.

### ***Word-of-Mouth Communication***

Word-of-mouth (WOM) communication is a powerful tool for marketers. WOM can be either positive or negative, specifically recommendations or praise or complaints. Positive WOM communication receives less attention although it is critical to the success of a business (File & Prince, 1992). WOM communication can reduce the cost of advertising when managed effectively (Sundaram, Mitra, & Webster, 1998).

This study focuses on informal communications about services, not formal complaints to the firm and/or personnel. Positive WOM communication is crucial to potential consumers (File & Prince, 1992). In fact, positive WOM doubles the likelihood of an information search and increases by four times the likelihood of purchase (eMarketer, 2010).



Personal communication or recommendation can come from both informal sources (friends, relatives, salespeople) and expert sources (advisers, seminars, associates) (File & Prince, 1992). Informal sources of recommendation from friends and family members were preferred among seniors (ARAMARK SLS, n.d.; Cavanaugh, 2003). Half of the applications for residence at Hyatt's Classic Residence at the Glen came from WOM referrals (Cavanaugh, 2003). WOM communication from a current customer to a potential customer is, in fact, often the most believable and unbiased method of stimulating new business for firms (eMarketer, 2010; Gremler, Gwinner, & Brown, 2001).

The literature shows positive WOM is a valuable tool for promoting products and services (e.g., ARAMARK, n.d.; Cavanaugh, 2003; Gremler & Gwinner, 2000; Gremler et al., 2001). In addition to satisfied customers (File & Prince, 1992), customers who have established long-term relationships with a service provider are likely to engage in positive WOM (Bendapudi & Berry, 1997). Gremler and Gwinner (2000) found both enjoyable interaction and personal connection between service employee and customer led to WOM.

The importance of interpersonal relationships between employees and customers is further supported by the findings of Gremler et al. (2001), who found a significant correlation between customer-employee relationships and customer WOM behavior. The authors also found customer satisfaction influenced customer WOM behavior in a separate model. Sundaram et al. (1998) found most (60%) positive WOM was due to satisfying product performance and employee-customer contact experience. Friendly, empathetic, responsive, and caring employee behavior is associated with positive WOM.

The relationship between customer satisfaction and WOM is generally accepted; however, some conflicting viewpoints illuminate this relationship (see Anderson, 1998). The relationship between customer satisfaction and WOM is not linear, as previously thought. In fact, WOM activity increases as satisfaction and/or dissatisfaction increases (Anderson, 1998). Although positive WOM is prized most, businesses should also strive to encourage customers to communicate complaints (negative WOM) to them, so they can remedy their mistake. According to DeWitt and Brady (2003), managing complaints can reduce or eliminate any damage, and a once dissatisfied customer can be retained.

In addition, gender might also play a role in WOM because women not only represent the largest number of residents in CCRCs; they also have the most influence on decisions for senior

living arrangements (ARAMARK, n.d.). Therefore, administrators of senior living facilities must satisfy both residents and their family members; their complaints and recommendations are highly influential sources of information that potential customers may seek. Furthermore, administrators also must understand the motives for engaging in WOM. For example, to encourage residents to spread positive WOM to help the facility, residents must have satisfying contacts with employees and quick responses to their problems.

Both positive and negative WOM communications are triggered by product performance, responses to problems, price/value perceptions, and employee behavior (Sundaram et al., 1998). Furthermore, consumers are motivated to engage in positive WOM by altruism, product involvement, self-enhancement, and helping the company. Alternatively, consumers are motivated to engage in negative WOM by altruism, anxiety reduction, vengeance, and to seek advice.

### ***Consequences of Satisfaction***

Review of previous research in marketing, specifically in the foodservice industry, shows that satisfaction leads to repeat custom (Anderson & Sullivan, 1993; Johns & Pine, 2002; Kim, 2009; Kim & Ok, 2010). Results from a meta-analysis of fifty studies found strong correlation between customer satisfaction and repurchase intention (Szymanski & Henard, 2001), which further suggests the importance of satisfaction for consumer's repurchase intentions. Thus, it seems prudent to also hypothesize that consumer satisfaction, achieved through service employee's customer orientation and subsequent relational benefits, would lead to positive behavioral intentions, specifically repurchase intentions.

Older adults are particularly accepting of personal sources of information (Cavanaugh, 2003; ARAMARK, n.d.), and both family and friends often influence them when they decide to enter a CCRC (ARAMARK, n.d.). Service firms are especially likely to benefit from WOM and personal sources of information because they rely on their customers to advocate, provide referrals, and bring new customers (Bendapudi & Berry, 1997; eMarketer, 2010; Gremler & Gwinner, 2000; Gremler et al., 2001).

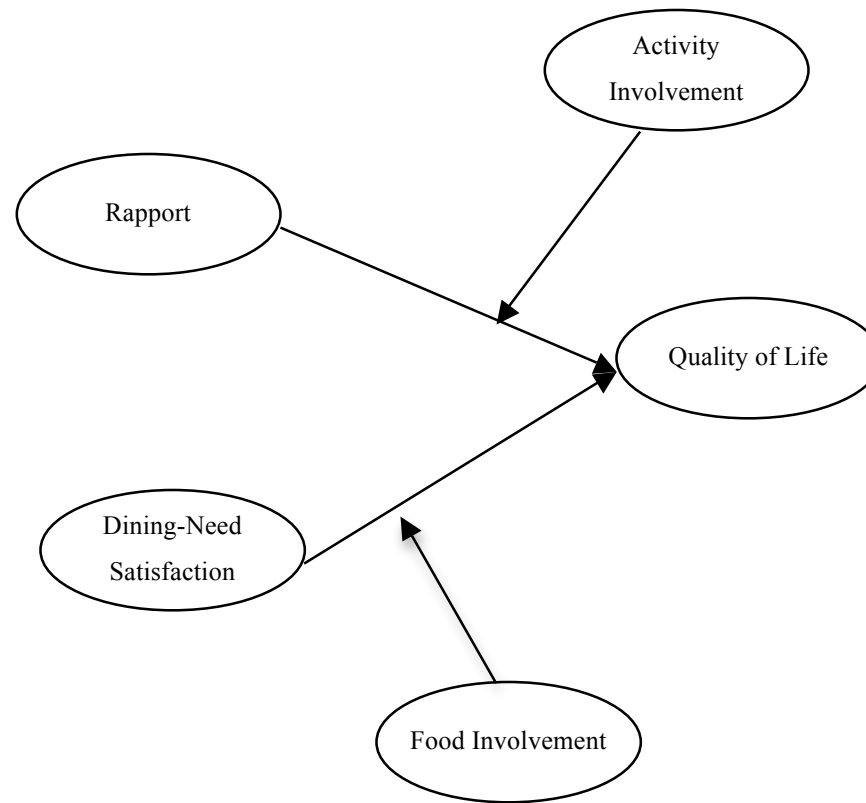
Previous studies show customer-to-employee interpersonal relationships lead to WOM (e.g., Gremler & Gwinner, 2000; Gremler et al., 2001), and that satisfactory contacts between employee and customer lead to positive WOM (Sundaram et al., 1998). Customer satisfaction

also influences customer WOM behavior (Gremler et al., 2001). Additionally, satisfied customers are more likely to advocate the service. Thus, the following hypotheses are advanced:

**H9:** Satisfaction has a positive effect on repurchase intention.

**H10:** Satisfaction has a positive effect on WOM intention.

**Figure 2.2** Proposed Conceptual Model for Study 2



## Study 2

The second model of this study investigates the roles of involvement (food and activity) as potential moderators of the association between rapport, dining-need satisfaction, and residents' quality of life.

### ***Rapport and Interpersonal Relationships***

The characteristic of a service encounter is such that the employee and the customer must interact with one another; however, customer participation may vary across services (Bitner et al., 1997). The role of a service provider during the service encounter is important because it is the first moment in which service occurs (Bitner, Booms, & Mohr, 1994). According to Sheth and Parvatiyar (1995), in situations where products or services are inseparable from the provider, consumers are likely to develop a relationship with the product-service provider. Moreover, consumers have better responses and commitments when marketers develop direct relationships with consumers.

As previously mentioned, the interaction between service provider and customer is unavoidable or almost certain in a service setting. This interaction provides an opportunity for socialization (Price & Arnould, 1999) and thus beginning the development of a relationship. According to Bitner et al. (1997), customers play a critical role in service creation and their own level of satisfaction. In addition, the service provider's friendliness and perceptions of similarity achieved over time contribute towards the development of a relationship. Additionally, services are predominantly performances in which service employees shape the service experience (Bendapudi & Berry, 1997).

Dwyer, Schurr, and Oh (1987) compared relational exchanges between buyer and seller to marriage, while Goodwin (1996) argued that service communality is similar to friendship. Furthermore, an ongoing relational exchange that considers both previous and future transactions is central to the definitions of relationships, that it transpires over time (Dwyer et al., 1987). In a service setting, functional conversation on service delivery is inevitable; however, for a relationship to ensue between employee and customer, behaviors such as transaction-irrelevant conversation, disclosure, and helping need to be present (Goodwin, 1996), akin to the enjoyable interaction and personal connection proposed by Gremler and Gwinner (2000). For this to be possible, four characteristics of service delivery situation (conversation time, self-disclosure,

physical environment, duration of relationship) could influence the perception of relationship (Goodwin, 1996).

In a CCRC, the possibility of the same customer or resident patronizing the foodservice establishment is high. In some CCRCs, residents are a ‘captured audience’ because residents in these facilities have paid for meals as part of their monthly dues. In fact, Cluskey (2001a; 2001b) found mealtimes for CCRC residents were a wonderful opportunity for socialization with the wait staff and other residents. Therefore, the same residents and service provider would likely interact frequently. Frequent interaction, service provider friendliness, and perceived similarity would lead to rapport.

Rapport is defined as a “customer’s perception of having an enjoyable interaction with a service provider employee, characterized by a personal connection between the two interactants” (Gremler & Gwinner, 2000, p. 92). According to the authors *enjoyable interaction* is a cognitive evaluation of the employee-customer interaction, while *personal connection* is the affiliation that the two individuals may have resulting from similarities or shared experiences.

Studies on rapport have been conducted over the years (e.g., DeWitt & Brady, 2003; Gremler & Gwinner, 2000; Gremler & Gwinner, 2008; Kim & Ok, 2010; Kim et al., 2010). Many of these studies have indicated the importance of rapport in developing relationships and customer satisfaction. Gremler and Gwinner (2000) found that both enjoyable interaction and personal connection were significantly related to satisfaction, loyalty intention, and word of mouth communication among bank customers. Kim and Ok (2010) found rapport leads directly to customer satisfaction and affective commitment, while indirectly affecting repurchase intention through affective commitment.

Hennig-Thurau (2004) found service employee’s social skills and motivation to fulfill customer needs strongly influence satisfaction and commitment, which leads to developing stable relationships with customers. Guenzi and Pelloni (2004) explored interpersonal relationships between customers and employees and found that customer-to-employee relationships lead to behavioral and attitudinal loyalty towards the firm, attitudinal loyalty towards the employee, and customer satisfaction. Kim et al. (2010) found that rapport positively influences customer relational benefits, which affect affective commitment and induces dedicational behavior among restaurant customers.

A number of studies have found that mealtimes provide fantastic opportunities for residents to form relationships with the wait staff, in addition to other residents (e.g., Ball et al., 2000; Cluskey, 2001a). In fact, Ryff (1989) found the interpersonal realm, being compassionate, caring, and having good relationships, was essential to middle aged and older adults. To gain repeat business, relational bonds between customer and employee must be created and nurtured (Dwyer et al., 1987; Donovan & Hocutt, 2001). In fact, businesses should strive for relationships that benefit both parties (buyer and seller) (Dwyer et al., 1987).

Indeed, findings by DeWitt and Brady (2003) confirmed the importance of developing relationships between service provider and consumer. The authors found that rapport established before service failure led to increased post-failure satisfaction, increased repatronage intentions, and decreased negative word-of-mouth after the initial failure had been put right. These findings indicate that it is beneficial for a firm to encourage their frontline employees to develop relationships with their customers.

### ***Dining-Need Satisfaction***

The construct dining-need satisfaction answers the question: Which individual's need would the consumption of food and dining satisfy? People consume food for a variety of reasons. Maslow's hierarchy of needs theory argues that human development encompasses higher-order and lower-order needs. Higher-order needs include the need for self-actualization, esteem, knowledge, and aesthetics. Lower-order needs are physiological, economic, and social. The hierarchy of needs theory identifies food as a basic physiological need. The primal purpose of consuming food is to satisfy hunger. Any type of food and beverage would fulfill this basic need. Food is the only product category that is consumed for both survival and nutritive purposes. Despite the undisputed importance of food to people in general, it is even more important to the health and well-being of older adults.

Nutritional attributes of food and beverage reinforce health and well-being contributing to the quality of life of older adults (ADA, 2000; Ball et al., 2000; Chao & Dwyer, 2004; Cluskey, 2001a; 2001b; Crogan et al., 2004; Lengyel, et al., 2004). "Proper nutrition prevents health problems; it can improve health, help avert impairments in functional status, and increase quality of life and well-being in older adults" (Amarantos, Martinez, & Dwyer, 2001; p. 57). Furthermore, inadequate nutrition results in malnutrition, morbidity, and mortality (Lengyel et

al., 2004). According to Sun (1995), American consumers are becoming increasingly sophisticated, demanding quality service with good value, convenience, and variety, while continuing to be health and nutrition conscious. In fact, among community dwelling older adults, nutritional quality was most important in selecting a place to eat (Becker-Suttle et al., 1994). Thus, it follows that nutrition is the second dimension of dining-need satisfaction.

In addition to the nutritional aspect of food and beverage, the sensory, psychological, and social aspects of food and eating must also be considered (Amarantos et al., 2001). A few studies have demonstrated that satisfaction with food services was associated with quality of life (e.g., Lengyel et al., 2004). Specifically, residents responded well to appropriate timing, variety on special occasions, amount or portion size, temperature of cold food, and service during mealtimes. Areas that needed attention (those receiving low positive responses) were food quality, variety, taste, and appearance. These findings were similar to other food, nutrition, and dining services studies among the elderly (e.g., Lee et al., 2003; Seo, 2005; Seo & Shanklin, 2005b). Eating is among the most important components of an elderly person's daily life (ADA, 2000); therefore it should receive the attention it deserves. Variety in taste, texture, and type of food should be considered in preparing food for the elderly; and thus considered the third dimension of dining-need satisfaction.

Multiple dimensions influence a meal experience (Andersson & Mossberg, 2004; Gustafsson, Öström, Johansson, & Mossberg, 2006). Findings in Andersson and Mossberg (2004) showed food as the basic requirement to fulfill the basic need for hunger, but an ideal meal would include additional satisfiers like *service, fine cuisine, restaurant interior, good company, and other customers*. The study found that customers were willing to pay more for an ideal meal than a basic meal. The Five Aspect Meal Model (FAMM) discussed in Gustafsson et al. (2006) revealed five aspects (i.e., *room, meeting, products, management control systems, and atmosphere*) that managers of foodservice establishments must consider. Lengyel et al. (2004) noted that food service delivery should occur in an environment that fosters autonomy, interpersonal relations, and security. Research shows socialization or social relationships are also critical for older adults (cf. Hinson Langford et al., 1997; Kawachi & Berkman, 2001), not only among residents within a CCRC, but with people outside the community (Stacey-Konnert & Pynoos, 1992).



According to Jhaveri (2006), seniors prefer an environment with intergenerational interaction to keep from feeling isolated from the world at large. Cluskey (2001b) noted that interpersonal relationships develop between residents and wait staff, which could fulfill the need for socialization. It also presents an opportunity for residents to have a link to the world at large, because employees live outside the retirement community with the general population. Thus, the fourth construct of dining-need satisfaction is socialization.

Following this line of argument, an individual's food and dining needs include food and beverage to satisfy hunger, nutritional need, and sensory need (taste/flavor, texture, temperature etc.), but also the need for socialization. In this study, we hypothesize a positive relationship between residents' quality of life and their dining-need satisfaction. That is, residents whose food/dining needs are fulfilled will also report better quality of life.

### *Quality of Life*

Quality of life (QOL) is often mentioned in studies involving residents of long term care facilities (cf. Ball et al., 2000; Crogan et al., 2004; Cummings, 2002; Jenkins, Pienta, & Horgas, 2002; Kane, 2001). Researchers however, have been unable to agree upon a definition of QOL although studies have used many dimensions to qualify it. Psychological well-being, social relations and interactions, and meaningful activity are among the domains of QOL (Ball et al., 2000). Kane (2001) identified eleven domains of QOL: safety, physical comfort, enjoyment, meaningful activity, relationships, functional competence, dignity, privacy, individuality, autonomy, and spiritual well-being. According to Seo and Shanklin (2005), enjoying food, good nutrition, and social interaction contribute towards the QOL for the elderly. Several studies have pointed to food as an important QOL indicator for residents in long term care settings (e.g., ADA, 2000; Crogan et al., 2004; Lengyel et al., 2004; Seo & Shanklin, 2005a).

A study among CCRC residents found activity engagement, particularly *active* activity is related to better QOL (Jenkins et al., 2002). Residents who participate in recreational activities, hobbies, socializing with friends, and taking walks or exercise have higher health-related QOL ratings for seven of eight domains. Furthermore, inactivity (time spent doing nothing) is inversely related to QOL. Residents of CCRCs often complain about the lack of variety and flexibility in recreational activities (Buelow & Fee, 2000). Some residents in the study wished for some activities conducted separately from disabled residents. Some family members also

complained that basket weaving and bingo as activities were insufficient for older adults who were still mentally capable.

Although recreational activity can be a platform for socialization, most CCRC residents reported ease of meeting and making friends following their move; however, those moving into CCRC from outside the county were a significantly higher number and were more likely to name other residents in the CCRC as close friends (Heisler et al., 2004). The positive effect of social relationships on mental health is generally understood (Hinson Langford et al., 1997; Kawachi & Berkman, 2001). One reason for moving into care facilities is to be around people (Ball et al., 2000). Several studies have suggested that social support might protect seniors from negative health and mental health outcomes (Cummings, 2002; Potts, 1997). Residents with depressive symptoms suffer from impaired psychological well-being and thus lower levels of life satisfaction (Cummings, 2002).

Symptoms of depression, anxiety, loneliness, and boredom can affect residents' general satisfaction with life (Ball et al., 2000). It is likely that interaction with others may alleviate some, if not all, of these emotional states. One way to ensure that residents remain independent for as long as possible is by prolonging the aging process through improving the level of functioning and overall health. This may be possible by improving residents' life satisfaction through controlling their depression (Cummings, 2002). However, social support in CCRCs might also come from interactions with service employees.

According to Ball et al. (2000), residents typically have three types of valued relationships: 1) family and friends outside the facility, 2) other residents, and 3) their formal caregivers. One group often unmentioned in the literature on long-term care facilities is in foodservice. These employees can usually interact with resident patrons of the foodservice establishments. In fact, Cluskey (2001b) reported that foodservice employees could identify subtle behavioral changes indicating the onset of Alzheimer's disease and symptoms of heart attacks or strokes for which early detection can make a difference. Clearly, service employees are essential to the well-being of residents.

Measures of QOL have been under-theorized, in that proxies such as health often measure it, and as such rather than measuring the QOL itself the result is a substitute of the measures of QOL with measures that describe the influences upon QOL (refer Wiggins, Netuveli, Hyde, Higgs, & Blane, 2008). Unlike other QOL measures, the World Health

Organization (WHO) has developed a QOL instrument that goes beyond traditional health indicators. The WHO defined QOL as an “individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHO, 1996, p. 5). The advantage of the World Health Organization’s Quality of Life (WHOQOL) instrument and definition is its worldwide versatility. According to WHO, QOL has four dimensions: physical, psychological, social, and environmental health.

Another QOL measure, CASP-19 is a subjective measure of well-being derived from the theory of human need spanning four life domains: control (C), autonomy (A), self-realization (S), and pleasure (P) (Wiggins et al, 2008). The first letter of each domain label was joined together to create the acronym, CASP. The instrument has been tested on national samples of older people living in England and Wales. The findings of the study revealed a shorter version of the measures (CASP-12) to be more reliable.

However, despite the versatility in definition of the WHOQOL, the use of the instrument is restricted, even the shortened version is too long and lacks practicality for the current research. On the other hand, the strength of the underlying theory and evaluation drive the usefulness of the CASP-12. As such, the CASP-12 was chosen to measure elderly residents’ QOL.

### ***Consequences of Rapport***

In a service setting, the interaction between service provider and customer provides an opportunity for socialization (Price & Arnould, 1999) and thus the beginning of a relationship. Friendliness and perceptions of similarity also contribute to the relationship. In a CCRC, a customer or resident will very likely patronize the same foodservice establishment each day. Therefore, residents and service staff would interact frequently. Relationships are the key to living (Kane, 2001), and older adults value relationships because they are crucial to the quality of life of older adults, especially as they experience more stressful life events. In addition, the elderly generally have more health problems and fewer resources, and they need supportive relationships. These interactions provide support, comfort, love, and affection (McGilton, 2002), all that make life worth living. Positive social ties are related to psychological well-being (Finch et al., 1989). QOL, psychological well-being, and social well-being are often mentioned

simultaneously. In fact, the WHO identified physical, psychological, social, and environmental health as dimensions of QOL (WHO 1996). Thus, the following hypothesis is proposed:

**H11:** Rapport has a positive effect on QOL.

### ***Consequences of Dining-Need Satisfaction***

Older adults need balanced diets to ensure their health and well-being. Meals provided in eldercare facilities allow care providers to better oversee residents' nutrition and health care. In fact, many older adults over 80 can live independently when three meals are provided (Cluskey, 2001b). Moreover, satisfying the nutritional needs of residents not only helps maintain physical health, but also mental health and QOL (ADA, 2000; Ball et al., 2000; Chao & Dwyer, 2004; Cluskey, 2001a; 2001b; Crogan et al., 2004; Lengyel et al., 2004).

It is hypothesized when an elderly person's needs for food, nutrition, senses (taste/flavor, texture, temperature, etc.), and socialization are met, the individual will have better QOL.

**H12:** Dining-need satisfaction has a positive effect on QOL.

### ***Activity Involvement***

Social relationships are important to older adults. Research generally agrees on the connection between social ties and mental health (Gilbart & Hirdes, 2000; Hinson Langford et al., 1997; Kawachi & Berkman, 2001). CCRC residents may develop social relationships with other residents through activities within the facility. More engaged older adults are more likely to have social support during stressful or difficult life events (Hinson Langford et al., 1997). Social support, whether emotional, instrumental, appraisal, and/or informational support, makes it even more likely for an older adult to recover after an injury or illness than those without social support.

According to Abbey, Abramis, and Caplan (1985), respondents (college students) who reported more social support had less anxiety, depression, interpersonal sensitivity, and more pleasant QOL. Stacey-Konnert and Pynoos (1992) investigated friendships and social networks among CCRC residents and found most residents (75%) relied on non-kin relationships within the CCRC for regular social activity. Informal social activities that require participation with others in a CCRC are playing cards, having cocktails, and dining together. In addition to developing relationships with other residents in the community, residents also established

relationships with caregivers and other CCRC employees (ADA, 2000; Cluskey, 2001b, McGilton, 2002).

Older adult's QOL is affected by their physical activity, social interaction, nutritional well-being, health, independence, and physical functioning (ADA, 2000). Active participation by older adults in planning and implementing new policies and programs were a key to ensuring their own needs are met. According to Stacey-Konnert and Pynoos (1992), men often assume the role of community leaders. Respondent residents could identify individuals who were active in the community; most respondents named the same core group of people.

Although the real advantage of living in a CCRC may be the potential to converse with people who are "articulate, intelligent, and had led diverse lives" (p. 303), a few respondents (6% or 3 respondents) reported that they did not have relationships with others within the CCRC (Stacey-Konnert & Pynoos, 1992). Those with health issues, cognitive deficiency, care-giving responsibility, a history of social isolation, the very old, and some widows tend to be socially inactive. These individuals are more likely to have mental health problems as a result of isolation from others.

Gilbart and Hirdes (2000) conducted a study among institutionalized older adults and found social engagement consistently predicted psychosocial well-being (measured using happiness, emotionality, and mood indexes). According to the authors, the Index of Social Engagement had the most significant effect in all models, suggesting social engagement as the most important variable for explaining variation in well-being among residents. As a corollary to these findings, it is proposed here that older adults' activities could have a positive effect on their QOL. Thus, the more involved or engaged an individual is in activities with others, the higher their QOL score.

### ***Moderating Effects of Activity Involvement***

Research has repeatedly shown that social interaction is crucial to elder adults' QOL and overall well-being (e.g., Ball et al., 2000; Jenkins et al., 2002; Kane, 2001; Kawachi & Berkman, 2001; McGilton, 2002) and may protect seniors from health and mental issues. Highly activity involved residents will be embedded in the social context of the facility through participation in a variety of activities. Residents willing to be involved in a facility's activities will have better QOL. Highly activity involved residents will take advantage of any opportunity for social

interaction. Such a resident would not only enjoy rapport with service employee, but also welcome any interpersonal interaction with them. Thus, it is proposed that rapport positively affects QOL, especially among socially engaged residents.

**H13:** Activity involvement moderates the relationship between rapport and QOL.

### ***Food Involvement***

A plethora of studies focus on consumer involvement; however, research generally lacks agreement on defining the construct and on scales for measuring it (refer to Bell & Marshall, 2003; Bloch, 1981; Laurent & Kapferer, 1985; Sun, 1995). Consumer involvement is an individual difference variable; it is a causal or motivating variable with consequences for consumer purchases and communication behavior (Laurent & Kapferer, 1985). The extent of consumer's decision process and information search depends on the level of their involvement.

Bloch (1981) has defined involvement as an ongoing interest, arousal or emotional attachment to the product in a particular individual (Bloch, 1981; Ladki & Nomani, 1996). According to Bloch, involvement varies across individuals, ranging from minimal levels to the extremely high levels. In consumer behavior studies, "level of involvement is assigned either as a personality characteristic of the individual toward a product or to the product categories themselves and often relates to the time investment involved in the choice decision, and includes the social risk of using or not using a product, and the financial risk relative to one's ability to pay for the product" (Bell & Marshall, 2003; p. 236). In line with the previous definitions, Ladki and Nomani (1996) defined an active (highly involved) shopper as "a consumer who spends resources in the acquisition of information related to the product prior to purchase" (p. 18). On the other hand, passive shoppers not only expend little effort searching for information before a purchase, they also depend heavily on WOM in purchase decision-making.

Traditionally, food as a product category is low involvement because of the low cost of food relative to total income (Bell & Marshall, 2003). However, this may be true only for food purchased and consumed domestically (at home). Based on a review of related literature, the consumer decision process for food or meals consumed outside the home seems to differ from that for home food. Among a few studies on consumer involvement in restaurant selection (e.g., Bloemer & Ruyter, 1999; Ladki & Nomani, 1996; Sun, 1995), full-service restaurant customers are highly involved in the service process (Bloemer & Ruyter, 1999). The authors also found a

significant difference between consumer involvement with quick-service restaurants than full-service restaurants. Perhaps the price or value difference and type of service drive involvement level.

In selecting a restaurant, consumers invest time and money to acquire an intangible experience (Sun, 1995). The risk and cost invested may cause consumers to feel more strongly about the product. According to Bell and Marshall (2003), food choices have both social and health risks. Today's consumers seek restaurants that provide quality food and service at an equitable price/value (Sun, 1995).

Marketing and consumer behavioral studies focus on consumer involvement because of its positive outcomes. Ladki and Nomani (1996) found that among active consumers, psychological involvement (opinion, belief, and behavioral intention but not attitude) correlated significantly with satisfaction. However, none of the psychological involvement dimensions correlated significantly with satisfaction among passive consumers. Kinard and Capella (2006) found consumer involvement level moderates the perceived relational benefits offered by the service provider; highly involved consumers perceived greater relational benefits than less involved consumers. Marshall and Bell (2004) reported on military personnel for whom meals were prepared and found higher levels of food involvement correlated with variety seeking, and highly involved individuals also tended to make healthier food choices.

Notably, rather than testing the usability of existing measures of involvement, Bell and Marshall (2003) developed a general food involvement measure built around the tasks associated with food choice. According to the authors, food involvement encompasses the overall domestic food provisioning cycle from the initial purchase of food to final disposal on the premise that food involvement is about more than simply eating (Bell & Marshall, 2003; Marshall & Bell, 2004). Varki and Wong (2003) and Kinard and Capella (2006), on the other hand, used Zaichowsky's (1985; 1994) Personal Involvement Inventory Scale (PII) to measure consumer involvement. The scale has been shown to have strong reliability with Cronbach's alpha values of .93 and .94 in Varki and Wong (2003), and .95 in Kinard and Capella (2006).

Indeed, Varki and Wong (2003) found that highly involved consumers showed more interest in establishing a relationship with service providers. Specifically, highly involved consumers of experiential service (e.g., long-distance telephone service) had a dedication-based or voluntary relationship, unlike consumers of credence service (e.g., general practitioner), who

engaged in both dedication-based and constraint-based relationships. Consequently, it is proposed that residents would appreciate the rapport from engaging with the service employees.

### ***Moderating Effects of Food Involvement***

Ladki and Nomani (1996) found a positive association between consumer involvement and consumer satisfaction. Highly food involved (active) consumers invest resources like time and effort gathering information before the actual dining occasion. Thus, the active consumer will have prior knowledge and, as a result, clearer expectations of the kinds of cuisine and service in the chosen establishment. When highly involved consumers invest resources that give them a more precise expectation of a service experience, they have more positive feelings with the outcome. Moreover, nutritional attributes of food and beverage also affect residents' QOL (ADA, 2000; Amarantos et al., 2001; Cluskey, 2001a; 2001b; Lengyel et al., 2004). Consequently, it is hypothesized that dining-need satisfaction positively affects QOL, especially among active/food involved consumers.

**H14:** Food involvement moderates the relationship between dining-need satisfaction and QOL.



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## **Chapter 3 - Research Methodology**

The purpose of this study was to investigate residents' perceptions of employees' customer orientation and interpersonal skills in relation to residents' satisfaction with foodservice and quality of life. To test the hypotheses, a cross-sectional study was conducted to investigate the relationships among the study constructs. This chapter describes the research methods and procedures that were used to achieve the research objectives of this study. The chapter begins with a description of the survey instrument development, measurement variables, followed by the population and sample used in the study, and a description of the pilot test. The final sections of the chapter describe the data collection procedure and data analyses.

### **Survey Instrument Development**

To empirically test the proposed models and to achieve the objectives of the study, a questionnaire was developed. Multi-item scales measured each of the 14 constructs included in the conceptual models. The following subsections discuss the measurements used in this study. In general, validated or established measures in the literature were adapted to a foodservice facility in the CCRC context with varying degrees of modifications, where available. This study used the items that have effectively measured these constructs based on their high level of reliability and validity in previous studies. The earlier part concentrates on the measures for the first study, discussed following the sequence of constructs shown in the conceptual model, from left to right in Figure 2.1. Subsequently, the constructs illustrated in Figure 2.2 will be discussed.

#### ***Study 1: Measurement Identification***

The four dimensions (motivation, social skills, technical skills, and perceived decision-making authority) of customer orientation of service employee (COSE) were measured using the 12 items previously used by Hennig-Thurau (2004), with slight modifications suitable for the context of this study. Technical skills questions were modified by providing specific examples of skills as mentioned by Kim (2009); including knowledge of menu, recipes, and ingredients. Specific examples for technical skills will enable elderly participants to respond more accurately to the measures, especially as the questions are based on their perceptions of employee's skills.

Few studies have used the same measures in foodservice settings (e.g., Kim, 2009; Kim & Ok, 2010) with Cronbach's alpha values exceeding the conventional cutoff points of .70 in



both studies. Considering the bulk of the arguments on COSE, this study builds upon the ideas, definitions, and findings of Hennig-Thurau and Thurau (2003) and Hennig-Thurau (2004); thus, it seems prudent for this study to use the same measures in these articles.

Of the three types of relational benefits, only two (confidence benefits and social benefits) were measured in this study. Confidence and social benefits were measured using the six items used by Gwinner, Gremler, and Bitner (1998). Three items from a total of six for the construct of confidence benefits, and three items from a total of five for the construct of social benefits were used in this study.

Three items used by Hennig-Thurau, Gwinner, and Gremler (2002) and Oliver (1980) were used to measure customer satisfaction. The behavioral outcome variables of repurchase intention was measured using three items from Hellier, Geursen, Carr, and Rickard (2003) and Cronin, Brady, and Hult (2000), and WOM measured using three items from Gremler and Gwinner (2000).

Five-point Likert-type scales ranging from 1 ('strongly disagree') to 5 ('strongly agree') were used. A total of 27 items were used for the first study. The original measurement items used in previous studies are shown in Appendix F; in addition, Table 3.1 presents the operationalization of the constructs in this study.

**Table 3.1** Description of Measurements of Constructs for Study 1

Dimensions	Measures	Source
Customer Orientation of Service Employee	<p>Based on all my experiences, a typical employee of this restaurant, ...</p> <ul style="list-style-type: none"> <li>▪ has adequate knowledge of the menu, recipes, and ingredients.</li> <li>▪ is expert in serving customers.</li> <li>▪ is highly competent in performing his/her job.</li> <li>▪ is always friendly and courteous.</li> <li>▪ is able to consider their customers' perspectives.</li> <li>▪ knows how to treat a customer well.</li> <li>▪ shows strong commitment to their job.</li> <li>▪ does their best to fulfill my needs.</li> <li>▪ is always highly motivated.</li> <li>▪ is allowed to decide freely in customer matters.</li> <li>▪ has authority to take action in solving customer matters.</li> <li>▪ does not need to ask their supervisor for permission in the case of customer requests.</li> </ul>	Hennig-Thurau (2004)
Confidence Benefits	<p>Based on all my experiences with this restaurant, ...</p> <ul style="list-style-type: none"> <li>▪ I believe there is less risk that something will go wrong.</li> <li>▪ I have more confidence the service will be performed correctly.</li> <li>▪ I have less concern when I buy the service.</li> </ul>	Gwinner et al. (1998)
Social Benefits	<p>Based on all my experiences with this restaurant, ...</p> <ul style="list-style-type: none"> <li>▪ I am recognized by certain employee(s).</li> <li>▪ they know my name.</li> <li>▪ I enjoy certain social aspects of the relationship.</li> </ul>	Gwinner et al. (1998)
Customer Satisfaction	<p>Considering my experiences with this restaurant, ...</p> <ul style="list-style-type: none"> <li>▪ I am very satisfied with the dining services it provides.</li> <li>▪ my choice to patronize this restaurant was a wise one.</li> <li>▪ overall, I am satisfied with the decision to patronize this restaurant.</li> </ul>	Hennig-Thurau et al. (2002); Oliver (1980)
Repurchase Intentions	<p>All things considered, as long as the present service continues, ...</p> <ul style="list-style-type: none"> <li>▪ I would keep dining out at this restaurant in the future.</li> <li>▪ I would dine out at this restaurant at least at current frequency in the future.</li> <li>▪ it is very likely that I will dine out at this restaurant again.</li> </ul>	Hellier et al. (2003); Cronin et al. (2000)
Word-of-Mouth	<p>Thinking of my relationship with this restaurant, ...</p> <ul style="list-style-type: none"> <li>▪ I would recommend this restaurant whenever anyone seeks my advice.</li> <li>▪ I go out of my way to recommend this restaurant, when the topic of restaurants comes up in conversation.</li> <li>▪ I have actually recommended this restaurant to my friends.</li> </ul>	Gremler and Gwinner (2000)

## ***Study 2: Measurement Identification***

Rapport measurements developed by Gremler and Gwinner (2000) were used in this study for dimensions of personal connectedness and enjoyable interactions. A total of three items were chosen from the original measures for each dimensions, giving a total of six items for the construct of rapport in this study.

No validated measures were available for the dimensions of dining-need satisfaction, so new measurements must be developed. The four dimensions of dining-need satisfaction introduced in this study were derived from a review of related literature. These dimensions are the need for *appeasing hunger*, *nutrition*, *sensory stimulation*, and *socialization*. In this study, it is suggested that food and foodservice must meet resident needs for all four dimensions, from least to most important, for them to experience overall dining-need satisfaction. Food service items used in senior care satisfaction studies (e.g., Chou, Boldy, & Lee, 2001; Lengyel, Smith, Whiting, & Zello, 2004) were used as a guide to develop the questions for this study. A total of 10 questions were modified for the construct.

A total of twelve items were chosen to represent the construct of quality of life (QOL) in this study. The CASP-12 was specifically designed to measure the QOL of elderly adults (Wiggins, Netuveli, Hyde, Higgs, & Blane, 2008). It is a self-reported summative index consisting of 12 Likert scale items that included statements from four life domains: control, autonomy, self-realization, and pleasure.

For activity involvement, the Revised Index of Social Engagement (RISE) developed by Gerritsen et al. (2008) was used in this study. The original Index of Social Engagement (ISE) was developed by Mor et al. (1995). Gerritsen and colleagues suggested that two items from the ISE lack the social orientation expected in scales that measure social engagement. The two items were “at ease of doing self-initiated activities” and “establishes own goals”. Findings from the 2008 study replaced the two items with “initiates interaction(s) with others” and “reacts positively to interactions initiated by others”. A total of four items relevant to the current study were chosen from Gerritsen et al. (2008).

A modified version of the Food Involvement Scale (FIS) developed by Bell and Marshall (2003) was used in this study. Of the 12 scale items developed, a total of four questions were

used in this study. Respondents were asked to indicate their level of agreement to four statements related to their personal food involvement.

All items were assessed on a 5-point Likert-type scale anchored from 1 ('strongly disagree') to 5 ('strongly agree'). A total of 36 items were used in the second study. The original measurement items used in previous studies are shown in Appendix F; in addition, Table 3.2 presents the operationalization of the constructs in this study.

**Table 3.2** Description of Measurements of Constructs for Study 2

Dimensions	Measures	Source
Rapport	<p>In this restaurant, there is a particular employee who(m)...</p> <ul style="list-style-type: none"> <li>▪ I enjoy interacting with.</li> <li>▪ creates a feeling of “warmth” in our relationship.</li> <li>▪ relates well to me.</li> <li>▪ I feel like there is a “bond” between us.</li> <li>▪ I look forward to seeing when I visit this restaurant.</li> <li>▪ I strongly care about.</li> </ul>	Gremler and Gwinner (2000)
Dining-Need Satisfaction	<p>The meals from this restaurant, ...</p> <ul style="list-style-type: none"> <li>▪ fulfill my hunger.</li> <li>▪ are just the right amount for me.</li> <li>▪ fulfill my need for nutritious food.</li> <li>▪ are good for my health.</li> <li>▪ are high in quality.</li> <li>▪ enable me to taste different types of food.</li> <li>▪ are served at the right temperature.</li> <li>▪ look appealing to me.</li> <li>▪ enable me to socialize with other people.</li> <li>▪ are suitable to be shared with family and friends.</li> </ul>	Chou et al. (2001); Lengyel et al. (2004)
Quality of Life	<p>Generally...</p> <ul style="list-style-type: none"> <li>▪ my age prevents me from doing the things I would like to. (R)</li> <li>▪ I feel that what happens to me is out of my control. (R)</li> <li>▪ I feel left out of things. (R)</li> <li>▪ I can do things that I want to do.</li> <li>▪ I feel that I can please myself with what I do.</li> <li>▪ shortage of money stops me from doing things I want to do. (R)</li> <li>▪ I look forward to each day.</li> <li>▪ I feel that my life has meaning.</li> <li>▪ I enjoy the things that I do.</li> <li>▪ I feel full of energy these days.</li> <li>▪ I feel that life is full of opportunities.</li> <li>▪ I feel that the future looks good for me.</li> </ul>	Wiggins et al. (2008)
Activity Involvement	<p>In thinking about the residents of this facility, I...</p> <ul style="list-style-type: none"> <li>▪ feel at ease interacting with them.</li> <li>▪ feel at ease doing planned or structured activities with them.</li> <li>▪ accept invitations to most group activities.</li> <li>▪ react positively to interaction initiated by others.</li> </ul>	Gerritsen et al. (2008)
Food Involvement	<p>When it comes to dining out, ...</p> <ul style="list-style-type: none"> <li>▪ I like to talk about what I ate or am going to eat.</li> <li>▪ I think much about food each day.</li> <li>▪ my food choices are very important compared with other daily decisions.</li> <li>▪ I think or talk much about how the food tastes.</li> </ul>	Bell and Marshall (2003)

*Note.* (R) denotes reverse coded items.

## **Survey Instrument**

The survey instrument consisted of four sections, including a demographic section. The first section of the questionnaire asked respondent to identify the foodservice establishment that they often patronize within the retirement community; in addition, the frequency of visits, and how long they have been a patron of the restaurant. The demographic section (section four) included questions on age, gender, ethnicity, marital status, education, living accommodation, length of residency at the facility, and residents' self-evaluation of physical health.

Generali (2010), who conducted a study among CCRCs and retirement communities' residents, consistently found that residents who received forms in font size 14 had higher mean ratings for ease of reading (in terms of instruction, font size, and wording of questions). Additionally, the study found the benefit of using capitalized and bolded words to emphasize the differences in similarly worded questions.

Randomization of order is suggested to minimize order effects; however, a study conducted among residents of assisted living facilities in a Midwestern state found cluster questions had higher reliability scores (Howells, 2007). It was easier for the respondents to process similar questions together instead of separately. Furthermore, the guideline for question sequencing in Trochim and Donnelly (2007) suggested to "ask about one topic at a time" (p. 112). As such the scale items will be group in accordance to the construct being measured (i.e., all COSE items will be asked in sequence).

To further assist elderly residents to answer the questionnaire, the 5-point Likert-type scale was placed on each page that requires residents to indicate their level of agreement. This is to ensure more accurate results by consistently reminding them of the scale used in the study.

## **Population and Sample**

The population of interest in this study was elderly residents in continuing care retirement communities (CCRCs) in the United States. However, given limited accessibility to the population, as well as limited financial resources and time, this study comprised convenience sampling of 412 elderly residents of five facilities listed in the directory of CCRCs in the United States. LeadingAge and Commission on Accreditation of Rehabilitation Facilities (CARF) International were used as sampling frame for the study. LeadingAge is a community of

nonprofit organizations in the U.S., state partners, businesses, research partners, consumer organizations, foundations and a global network of aging services that reach over 30 countries (LeadingAge, n.d.). CARF International is an independent, nonprofit accreditor of health and human services (CARF, 2012).

The directory lists approximately 1060 CCRCs in the United States; CCRCs located in the Midwest, specifically in Kansas and Missouri were selected for this study. The selection criteria comprised large facilities with both independent and assisted living accommodations with 50 or more residents and on-site dining facilities. Retirement facilities with less than 50 residents were excluded because foodservice is often limited in these facilities. A total of five facilities with the number of independent and assisted living residents ranging from 131 to 570 participated in this study.

### **Pre-Test and Pilot Test**

Faculty members and graduate students in a hospitality program evaluated the content validity, including its clarity of wording of individual items of the questionnaire. To measure the internal consistency reliability of the questionnaire, a pilot test was carried out among elderly or senior residents at a selected facility. Group surveys consisting of 10 to 15 respondent residents were conducted, with the researcher present to ensure respondents have their questions answered should any arise. Residents were asked in advance to participate in the pilot study, prior to the scheduled survey sessions. Information regarding the survey sessions was advertised in the facility's newsletter and television station. Two separate sessions were scheduled on two consecutive days and at different times of day (one morning session and one afternoon session), to encourage residents' participation. Pilot test participants were excluded from the actual/main research survey.

During the pilot test sessions, participants were asked to complete the questionnaire and to identify any ambiguity of questions, and measurements, in addition to providing suggestions for the improvement of the instrument itself. The researcher was present at all times to answer questions as well as to observe participants' completion of the questionnaire. A total of 22 residents were surveyed and asked to review the questionnaire.

### ***Construct Reliability***

Reliability refers to the consistency or repeatability of your measures (Trochim & Donnelly, 2007). It determines how accurately your measurement scores will be reproduced with repeated measurement. The internal consistency reliability coefficient alphas of the measurements used in this study were calculated. Cronbach's alpha for all constructs ranged from .80 to .98, higher than the recommended value of .70 (Nunnally, 1978) indicating the instrument had good internal consistency as presented in Table 3.3. However, two constructs: food involvement and QOL had alpha values lower than recommended.

In line with the findings from the pilot test, few questions were modified to improve the research instrument. The QOL scale ( $\alpha = .69$ ) was left as it is for the final questionnaire as it is considered to be good at this stage even though it is below .70. The scale used for measuring food involvement was modified by positively wording all the negatively worded measures.

During the pilot test, it was observed that some respondents had problem comprehending some of the statements in the questionnaire. As such, these statements were modified, particularly those utilizing complicated vocabulary that may cause participants to misunderstand the statements. For example the statement "is allowed to decide autonomously in customer matters" was modified to "is allowed to decide freely in customer matters". A simpler word *freely* replaced the more complicated word *autonomously* in the example. Another example, "has *appropriate room to maneuver* in solving customer matters" became "has *authority to take action* in solving customer problems".

To further improve the instrument, the specific name of the restaurant within the selected facility that fulfills the criteria required for this study was also included in the final questionnaire. For facilities with multiple restaurants, the names of every establishments that fit the requirement of this study were included in the questionnaire. This is to ensure participants' responses will be based on their experiences with a particular restaurant within the CCRC. Additionally, page numbers were also inserted into the final questionnaire because a number of pilot test participants had missed entire pages of the questionnaire. Data from these participants were excluded from the reliability analyses. The composite reliability (CR) of constructs in the actual study survey were all above .70.



**Table 3.3** Internal Consistency Reliability of Measurements in Pilot Test

Construct	Cronbach's Alpha
Technical skills	.80
Social skills	.83
Motivation	.89
Decision-Making Authority	.83
Confidence benefits	.85
Social benefits	.92
Satisfaction	.96
Repurchase intentions	.98
Word-of-Mouth	.93
Rapport	.93
Dining-need satisfaction	.92
Quality of life	.69
Activity involvement	.80
Food involvement	.40

### Use of Self-Report Questionnaire

This study is based on a self-reported questionnaire; all data were gathered from the respondent's personal responses to the questions. Although the interview method with structured questionnaire is preferred for data collection among elderly senior care residents (cf. Atherly, Kane, & Smith, 2004; Cummings, 2002; Heisler et al., 2004; Krout, Oggins, & Holmes, 2000; Lengyel et al., 2004), self-report questionnaire was chosen in this study because of multiple reasons.

Previous study has been successful in collecting data with this method among institutionalized elderly samples (e.g., Chou, et al., 2001). The study revealed that respondents of that study tend to respond positively for fear of repercussions. Respondents of the current study must understand that all information gathered in this study is confidential and anonymous so that respondents have the freedom to divulge their true opinions and feelings.

Despite disadvantages associated with the self-report method like common method variance (CMV) or social desirability response bias which may lead to inflated correlations among the variables (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003), the self-report method was chosen because the variables measured in the study reflect personal attitudes, emotions, perceptions, and values, which are measurable only by the respondents' self-reporting (Spector, 2006). Other sources like healthcare provider (e.g., nurses, personal aids), service employees and family members are unlikely to have knowledge of the respondents' states of mind.

Additionally, information gathered during the pilot test of this study also influenced decision regarding the method for data collection. Participants expressed comfort with the self-reporting method. Being able to decide when and where to complete the questionnaire also encouraged additional participation among the residents of the pilot test facility; residents kept asking if it would be possible for them to complete and return the questionnaire at their own convenience. This is important because an elder respondent may need more time and not feel obligated to complete the questionnaire in one sitting. This is also an effective way of controlling occasion factors that may influence measurement at a given point in time (i.e., mood) (cf., Spector, 2006).

### **Data Collection Procedure**

This study complied with the mandate of the KSU Institutional Review Board (IRB) for research involving human subjects.

#### ***Sample Selection and Data Collection***

Independent and assisted living residents from the selected facilities who frequent campus dining establishments were the target of this study. Facility administrators and/or foodservice directors of the selected facilities were first contacted to ascertain their eligibility and interest in the study. The purpose of the study and other further concerns were explained at this time. CCRCs with dining facilities that employ wait staff (e.g., restaurant style dining facilities that serve a la carte meals) were eligible for this study. Upon approval, the researcher personally met with each facility's contact person to deliver survey packets and to discuss the research protocol.

Information regarding the upcoming survey was advertised in the facility's newsletter, television station, and/or research flyers posted in strategic locations around the facilities. Residents were asked in advance to participate in the study, prior to the distribution of the survey packets through their mailboxes by the facility's contact person. Eight hundred and sixty-seven survey packets were distributed among residents in the selected facilities. The survey packets consisted of the cover letter (Appendix A), questionnaire (Appendix B), and gift card drawing entry form (Appendix C) placed in a prepaid self-addressed envelope (addressed to the researcher). A total of 412 residents completed the questionnaire (47.5% response rate) from five different facilities. The majority (65.0%) of the questionnaires were returned by mail. The

researcher collected just over a third (35.0%) of the questionnaires from facilities A, C, D, and E within two weeks of the initial distribution of the survey packets.

### ***Incentives for Participants***

As an incentive, respondents have an option to participate in drawings for a \$50 dollar gift card for every ten participants in their facility. Each respondent has a 1 in 10 chance of winning the gift card. To participate in drawings, respondents were asked to provide personal information including their name, mailing address, and phone number (Appendix C). Respondents were informed that if they were chosen in the drawings, additional mail would be sent requesting their social security number in order to receive the gift card. As a result of the social security number requirement, one of the five facilities included in this study (Facility E) opted out from receiving the incentive.

### ***Anonymity and Confidentiality***

Upon receiving each completed survey packets, the gift card drawing forms with respondent's name and contact information were immediately separated from the completed questionnaire. Each survey packet was coded to differentiate survey packets from different facilities in order to track the response rate. No other numbers or other information was placed on the questionnaires before they were distributed. Confidentiality and anonymity were guaranteed.

### **Data Analysis**

Statistical analyses were performed using IBM SPSS Statistics 20 (IBM Corporation, Armonk, NY) and AMOS 20 (IBM Corporation, Armonk, NY). Prior to analysis, dependent and independent variables were examined for accuracy of data entry, missing values, and outliers. A total of 412 questionnaires were completed and returned to the researcher. The following subsections discuss the data analysis procedure in detail, beginning with diagnostics for data entry and missing values, followed by evaluation of the quality of measurement properties, and finally tests for hypotheses.

### ***Data Screening***

The first step taken to ensure the integrity of the data was to check the accuracy of the data coding and entry into the statistical computer program (SPSS). To complete this task, the minimum and maximum values, means, and standard deviations of each of the variables were inspected for plausibility.

Cases with whole pages of missing data were removed from further analysis (except for those respondents who did not complete the whole page for demographic data). As the questionnaire consisted of multi-item scales with a minimum of three measurement items for each construct, cases with one and no missing value for each study were included for further analysis. Missing values were replaced with the case's construct's mean (instead of the overall mean for the construct).

A total of 354 cases each for study 1 and 2 were subsequently used for further analysis. Missing value analysis (MVA) revealed variables used in study 1 were missing completely at random (MCAR); however, Little's MCAR was significant ( $p < .05$ ) for variables in study 2. To further determine the severity of missing values, paired sample *t*-tests were conducted to compare between scores with missing values and scores with mean replacement. Results revealed no significant difference ( $p > .05$ ) between the scores with missing values and scores with mean replacements.

### ***Confirmatory Factor Analysis***

Prior to hypotheses testing of the conceptual models of this study, two separate confirmatory factor analysis (CFA) were conducted to assess reliability and validity (convergent and discriminant) of the constructs included in the two models. CFA was first applied as preliminary analysis to evaluate the dimensionality of the measurement items that connect to corresponding latent variables simultaneously (Anderson & Gerbing, 1988). The goodness of fit of the measurement models was also assessed.

### ***Construct Validity***

Construct validity refers to the extent to which a set of test measures of the concept or construct accurately represents the concept of interest (Trochim, & Donnelly, 2007). The two

most widely accepted forms of construct validity; convergent and discriminant validity (Hair, Black, Babin, & Anderson, 2010) were examined.

### ***Convergent Validity***

Convergent validity was determined by 1) examining the factor loadings of measurement items on their corresponding latent construct, 2) evaluating the average variance extracted (AVE) for each construct, and 3) comparing the construct's composite reliability (CR) and AVE.

CFA was first applied as preliminary analysis to evaluate the dimensionality of the measurement items to the corresponding latent variables (Anderson & Gerbing, 1988). Factor loadings of manifest variables on their respective latent variables greater than .70 and significant at the alpha level of .001, would satisfy the convergent validity criteria. Alternatively, according to Hair et al. (2010) standardized loadings estimates should be .50 or higher, and ideally .70 or higher.

AVE higher than .50 indicates more than half of the variance in the construct was explained by their corresponding measures (Fornell & Larcker, 1981; Hair et al., 2010). To confirm convergent validity, the construct's CR should be higher than the construct's AVE. All 14 constructs in study 1 and 2 had CR higher than their corresponding AVE.

### ***Discriminant Validity***

Discriminant validity was evaluated by comparing the squared correlations or coefficient of determination ( $R^2$ ) of the paired constructs with the AVE of each corresponding constructs (Fornell & Larcker, 1981; Hair et al, 2010). Discriminant validity is confirmed if the  $R^2$  between the pair of constructs is less than the AVE for each construct (Fornell & Larcker, 1981).

In the event that the above requirement is not satisfied, a further analysis to assessed discriminant validity involves constraining the correlation between the pair of factors to unity (Anderson & Gerbing, 1988). A significantly lower chi-square ( $\chi^2$ ) value for the unconstrained model indicates that the two are not perfectly correlated, demonstrating discriminant validity.

### ***Goodness of Fit Index***

Measures of goodness of fit test how well a specified latent variable structure or measurement model actually reproduces the observed correlation or covariance matrix for the indicators used to define a scale (cf. Wiggins et al., 2008). In addition to the raw chi-square ( $\chi^2$ ),

the degree of freedom ( $df$ ), probability value ( $p$ ) are reported. However, due to the limitation associated with the  $\chi^2$ , other goodness of fit indexes will also be reported (cf. Byrne, 2001; Wiggins et al., 2008). Namely, comparative fit index (CFI), Tucker-Lewis index (TLI), increment index of fit (IFI), and root mean square error of approximation (RMSEA) will also be reported. Table provides the interpretation of fit for the indexes.

**Table 3.4** Guide to evaluating ‘Goodness of fit indices’

Index	Interpretation of fit
Deviance of CMIN/ $df$	>2.0 Not so good
	>0.90 Good
Comparative fit index (CFI)	>0.90 Good
	>0.95 Very good
Tucker-Lewis index (TLI)	>0.90 Good
	>0.95 Very good
Increment index of fit (IFI)	>0.90 Good
	>0.95 Very good
Root mean square index of approximation (RMSEA)	>0.10 Poor
	<0.05 Good

### ***Hypotheses Tests***

A satisfactory level of validity and reliability of measurement model has to be met before testing for significant relationships in the structure model (Fornell & Larcker, 1981). Two different approaches were used to test the hypotheses in study 1 and 2. Structural equation modeling (SEM) was utilized to examine the hypothesized relationships in model 1 (Figure 2.1). To test the moderating effect of involvement (food and activity) in model 2 (Figure 2.2) hierarchical multiple regressions analyses were conducted.

### ***Descriptive Statistics***

Descriptive analysis (means and standard deviations) was performed on all measurement items. Additionally, frequency analysis was carried out on several demographic measures to determine the overall characteristics of respondents in comparison to the general CCRCs’ population. Findings on respondents’ characteristics including age, education, years of stay, and marital status are also reported.

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## **Chapter 4 - The Role of COSE and Relational Benefits on CCRC Residents' Satisfaction and Behavioral Intentions Towards Dining**

### **Abstract**

As the number of older adults increases, so does the demand for housing and personal care needs. The continuing care retirement community (CCRC) is unique from other long-term care facilities as it provides a continuum of housing and care that caters towards an individual's need. Foodservice is often utilized to attract older adults into retirement facilities, making it a lucrative segment for the foodservice industry; hence, the increasing interest among hospitality companies. In order to benefit from this segment, more research is needed to better understand the population's needs and wishes regarding food and services. Research regarding CCRC residents' perception of customer-to-employee interaction is scarce. This study fills this chasm in literature by examining the relationships between the dimensions of customer orientation of service employees with relational benefits, and subsequently customer satisfaction, repurchase intention and word-of-mouth. This study will provide a better understanding for the retirement facilities' administrators regarding their residents' perception of dining services offered. To empirically test the proposed relationships, data were collected from 412 CCRC residents in five separate facilities. A total of 354 surveys were used for further analysis. The results of structural equation modeling suggested that only technical skills, social skills, and motivation (three of the four dimensions of COSE) had significant positive relationships with confidence and social benefits. Confidence and social benefits in turn, had positive effect on customer satisfaction. Finally, customer satisfaction explained certain variations in repurchase intentions and word-of-mouth communication. Further discussion and managerial implications of the findings along with directions for future studies are provided.

*Keywords:* customer orientation of service employees (COSE); confidence benefits; social benefits; customer satisfaction; repurchase intention; word-of-mouth; continuing care retirement communities (CCRCs); dining services

## **Introduction**

The number of seniors globally has increased dramatically as a result of better health and improved life expectancy. There are approximately 40.4 million older Americans aged 65 years and older in 2010, representing 13.1% of the total U.S. population (Administration on Aging [AoA], 2011). The number of the over-65 population rose comparatively faster than the under-65 population; with an increase of 5.4 million or 15.3% since 2000 for the former compared to 8.7% increased for the latter (AoA, 2011). This poses a significant challenge for senior services in particular with the increasing need of affordable housing and personal care needs of older adults.

The continuing care retirement communities (CCRCs) offer a combination of residential and health care services. Unlike other senior care facilities, CCRCs provide a full range of housing, social and additional services, and health care to serve residents as their needs change over time (Ball et al., 2000; Chao & Dwyer, 2004; Hawes, Phillips, Rose, Holan, & Sherman, 2003; Krout, Oggins, & Homes, 2000). Residents have the flexibility and security for aging in place, as they are able move through the different levels of care as their health dictates (American Association of Homes and Services for the Aging [AAHSA], 2008; Position of the American Dietetic Association [ADA], 2000; Cluskey, 2001b).

In recent years, the services offered in CCRCs have been shaped largely by the demand of current residents as well as community dwelling seniors who anticipate their own future care needs. In contrast to other traditional senior care facilities, CCRCs are hospitality oriented rather than healthcare oriented (Lee, Shanklin, & Johnson, 2003). On-site food and dining services have become increasingly important to current and potential CCRC residents; hence the trend towards full-service dining (Buzalka, 2005; Cavanaugh, 2003). In addition, changes in foodservices within CCRCs have resulted particularly as leading hospitality companies (e.g., Marriot International and Hyatt Corporation) have pervaded the industry. In fact, Hyatt's Classic Residence occupancy was driven by its upscale dining services.

Many facilities emphasize wellness and keeping residents as independent as possible by adapting their services to accommodate residents' demand for assistance with primary health care, self-care (bathing, dressing, toileting, transferring, and eating), as well as social, cultural, and educational programs (Assisted Living Federation of America [ALFA], 2009; Cluskey, 2001b; Tindell, 2002). Food is an important component in the life of an older adult. Employees

are better enabled to oversee residents' physical and mental health, as well as their quality of life in general with the provision of food (Ball et al., 2000; Cluskey 2001a, 2001b; Crogan, Evans, Severtsen, & Shultz, 2004). Furthermore, food satisfies residents' nutritional needs, while mealtimes provide residents with opportunities to socialize. Quality of services and quality of life of each resident are emphasized in CCRCs.

Although previous studies have discerned that mealtimes provide great opportunities for residents to form relationships with the wait staff, as well as other residents (e.g., Ball et al., 2000; Cluskey, 2001a), to the best of the researcher's knowledge, studies have yet to examine the relationship between resident and foodservice employee in senior care setting. This study seeks to fulfill this gap, and proposes that the principles found in the commercial restaurant industry also apply to dining services in CCRCs.

Most academics and practitioners alike accept the principle of customer retention to be one that observes better business practice than one that constantly seeks new customers. Developing and maintaining enduring relationship is one way to retain current customers. Studies have shown that customer-to-employee relationship leads to customer-to-firm relationship (e.g., Guenzi & Pelloni, 2004; Kim, Ok, & Gwinner, 2010). Customers are willing to remain in long-term relationship with a firm if it is beneficial to them (Barnes, 1994).

The behavior of a service employee when serving the customer can greatly influence their overall evaluation of the service and future intentions. Customer orientation of service employees (COSE) has been proven to be an important antecedent of customer satisfaction and relational benefits. This study determined the impact of COSE on the way CCRC residents assessed transactions with foodservice employees. Specifically, the relationships among individual dimensions of COSE with residents' perceptions of confidence and social benefits, customer satisfaction, and the subsequent repurchase intention and word-of-mouth were examined.

## **Theoretical Background and Hypotheses**

### ***Customer Orientation of Service Employee***

Central to marketing is that activities should be directed toward ensuring customer satisfaction and creating mutually beneficial, enduring relationships with the market (Kotler,

1980). A way to do this is by putting customer's interests first (Saxe & Weitz, 1982). Customer orientation is central to the marketing concept and philosophy (Donavan & Hocutt, 2001; Hennig-Thurau & Thurau, 2003; Morgan, 1996; Saxe & Weitz, 1982) and relationship marketing (Hennig-Thurau & Thurau, 2003).

Customer orientation of service employee (COSE) is "the behavior of service employees when serving the needs and wishes of existing and prospect customers" (Hennig-Thurau & Thurau, 2003, p. 27). COSE consists of four interdependent dimensions of technical skills, social skills, decision-making authority, and motivation. COSE has been studied in the full-service restaurant setting (e.g., Kim, 2009; Kim & Ok, 2010), and has been found to affect customer satisfaction (Hennig-Thurau, 2004; Kim, 2009; Kim & Ok, 2010; Susskind, Kacmar, & Borchgrevink, 2007). Furthermore, a previous study found COSE to positively affect relational benefits (Kim, 2009).

Foodservice employees play a key role in determining the customer satisfaction, and customer satisfaction in turn is an important determinant of the restaurant's profitability and longevity. Employees who are more customer-oriented would be more likely to engage in activities designed to build customer satisfaction. In the CCRC setting, the same resident-customer would patronize the restaurant day-in day-out, and the same foodservice employee would service the resident. As such, the likelihood for resident and employee to develop interpersonal relationship is high.

### ***Relational Benefits***

The concept of relational benefits is based on the belief that the customer remains in a long-term relationship only when the relationship benefits them (Gwinner, Gremler, & Bitner, 1998). Relational benefits are additional benefits that customers receive beyond the core service: *confidence*, *social*, and *special treatment* (Gwinner et al., 1998). Of the three, consumers rated confidence benefits as consistently more important, followed by social and special treatment benefits. Confidence benefits are important to consumers; they have reduced anxiety and less perception of risk because they know what to expect from the service relationship and have increased faith in the trustworthiness of the service provider. Social benefits include personal recognition by employees, familiarity with employees, and friendship. Special treatment benefits, on the other hand, include price savings or breaks and special service. In the CCRC setting,

residents are likely to experience confidence and social benefits. As such, only two of the three relational benefits will be assessed in the present study.

COSE is an important antecedent of relational benefits; moreover, relational benefits (particularly confidence benefits and special treatment benefits) affect customer satisfaction through favorable inequity (Kim, 2009). COSE possibly leads to relational benefits as a result of the development of a relationship. Customer oriented employees with the social skills and motivation to fulfill customer needs can influence customer commitment, leading to a stable relationship with customers (Hennig-Thurau, 2004).

The process of aging is characterized by physical, physiological, and social changes that generally make the elderly more vulnerable to deteriorating health, fewer resources, and greater need for supportive relationships. Thus, it is not surprising that older adults emphasized the interpersonal dimension; being a caring and compassionate person and having good relationships with others (Ryff, 1989). Social interaction is an important activity for older adults, and studies have shown that mealtime often offers dual benefits improving their quality of life through both nutrition and socialization (e.g., ADA, 2000; Cluskey, 2001a). The development of a stable relationship between customer and foodservice employee in a CCRC could affect a customer's perception of social benefits.

### ***COSE to Confidence Benefits***

Unlike previous studies (e.g., Kim, 2009; Kim & OK 2010), the current study analyzed the effect of the first-order dimensions of COSE (technical skills, social skills, decision-making authority, motivation) on relational benefits (confidence, and social benefits), customer satisfaction and subsequent behavioral intentions (repurchase intention and word-of-mouth).

Customer-oriented service personnel are highly motivated, with technical skills, social skills, and perceived decision-making authority to fulfill the needs and wishes of customers (Hennig-Thurau & Thurau, 2003; Hennig-Thurau, 2004). Such an employee will deliver quality service and, as a result, enhance customer's satisfaction. Pettijohn, Pettijohn, and Taylor (2004) administered a study among restaurant wait staff and found positive relationships exist between employee customer orientation and sales skills. Motivation is absolutely necessary for employees' technical and social skills to be expressed through behavior (Hennig-Thurau, 2004).

Perceived decision-making authority is expected to have a positive influence on employee's motivation to behave in a customer oriented manner.

A service employee with the motivation, technical knowledge, and decision-making authority can assist the customer with the menu, provide suggestions, and fulfill specific requests. Such an employee will provide quality service that would reduce customers' perceptions of anxiety and risk; knowing what to expect from the service relationship and have increased faith in the trustworthiness of the service provider (Gwinner et al., 1998). In other words, customers have increased confidence benefits. In line with this, the following is hypothesized:

**H1:** Employee's technical skills have a positive effect on confidence benefits.

**H2:** Employee's decision-making authority has a positive effect on confidence benefits.

**H3:** Employee's motivation has a positive effect on confidence benefits.

### ***COSE to Social Benefits***

Hennig-Thurau (2004) found that service employee's social skills and motivation to fulfill customer needs strongly influence satisfaction and commitment, leading to the development of stable relationships with customers. According to the author, an employee must possess all dimensions of COSE (motivation, perceived authority, and skills) in order to behave in a CO manner. This study postulates that service employees who possess the motivation, social skills, and decision-making authority are likely to recognize and be familiar with the consumer. In addition, a customer-oriented employee is more likely to build a relationship with the customer.

Social interaction is especially important for older adults and mealtimes provide wonderful opportunities for socialization (e.g., ADA, 2000; Cluskey, 2001a). Stacey-Konnert and Pynoos (1992) observed that most (approximately 75%) CCRC residents had, on average, more social interactions within the community; they socialized with three non-relatives in the CCRC but only one non-relative outside the CCRC. Additionally, residents often report a variety of social activities.

Developing a stable relationship between the customer and the foodservice employee in the CCRC, derived from employee's social skill, motivation, and decision-making authority

could affect a customer's perception of social benefits. Thus, the following three hypotheses were proposed:

**H4:** Employee's social skills have a positive effect on social benefits.

**H5:** Employee's motivation has a positive effect on social benefits.

**H6:** Employee's decision-making authority has a positive effect on social benefits.

### ***Customer Satisfaction***

Customer satisfaction is the "degree of overall pleasure or contentment felt by the customer, resulting from the ability of the service to fulfill the customer's desires, expectations and needs in relations to the service" (Hellier, Geursen, Carr, & Rickard, 2003; p. 1765). It has been the central construct in many studies; and is an important concept in marketing. The proliferation of studies on customer satisfaction stems from its profit generating potential. Studies in senior care settings have covered a variety of subjects from residents' satisfaction with facilities and services (e.g., Buelow & Fee, 2000; Chou et al., 2001; Young & Brewer, 2001) to the development and evaluation of measurement tools (e.g., Atherly et al., 2004; Lengyel et al., 2004).

The construct is often used as a predictor of revisit intention (Dube, Renaghan, & Miller, 1994). Findings from previous study revealed that satisfaction leads to repeat purchase intention (Anderson & Sullivan, 1993; Cronin & Taylor, 1992; Dube et al., 1994; John & Pine, 2002; Kim, 2009; Kim & ok, 2010, Szymanski & Henard, 2001) and loyalty intentions to the firm (Guenzi & Pelloni, 2004). Cronin, Brady, and Hult (2000) found service quality, value, and satisfaction were directly related to positive word-of-mouth, recommendation to other consumers, loyalty or repurchase, and a willingness to spend more with the company.

### ***Confidence Benefits and Social Benefits to Customer Satisfaction***

Any benefits received beyond the core service very likely will increase consumer satisfaction. Relational benefits, particularly confidence and social benefits, would lead to satisfaction. Perceiving less risk and having more confidence in the trustworthiness of the service provider will positively affect consumer satisfaction; additionally, personal recognition, familiarity, and friendship built through interaction with a service employee will likely affect consumer satisfaction. In fact, Kinard and Capella (2006) found confidence benefits influenced consumer loyalty and satisfaction levels. Thus, the following hypotheses were advanced:

**H7:** Confidence benefits have a positive effect on satisfaction.

**H8:** Social benefits have a positive effect on satisfaction.

### ***Behavioral Intentions***

Favorable behavioral intentions are associated with a service provider's ability to get the customers to 1) say positive things about them, 2) recommend them to other consumers, 3) remain loyal to them (i.e. repurchase from them), 4) spend more with the company, and 5) pay price premiums (Cronin et al., 2000; Zeithaml et al., 1996). Two behavioral intentions assessed in this study were repurchase intention and positive word-of-mouth communication.

#### ***Repurchase Intention***

Repeat purchase intention is an important indicator of business's success, at times more useful than customer satisfaction (Dube et al., 1994). Repeatedly, studies support the relationship between customer satisfaction and repurchase intention (Anderson & Sullivan, 1993; Cronin & Taylor, 1992; Cronin et al., 2000; Fornell, 1992; Szymanski & Henard, 2001), suggesting that a firm is likely to retain customers as their satisfaction increases. Further, consumers may show their loyalty to a service provider through repurchasing (Cronin et al., 2000; Zeithaml et al., 1996).

#### ***Word-of-Mouth Communication***

Word-of-mouth (WOM) communication is a powerful tool for marketers. It can reduce the cost of advertising (Sundaram, Mitra, & Webster, 1998), double the likelihood of information search, and increase by four times, the likelihood of purchase when managed effectively (eMarketer, 2010).

WOM from current customer to potential customer is considered the most believable and unbiased method of stimulating new business (eMarketer, 2010; Gremler, Gwinner, & Brown, 2001). Informal sources of recommendation from friends and family members were preferred among seniors (ARAMARK Senior Living Services [ARAMARK], n.d.; Cavanaugh, 2003). There is a significant correlation between customer-to-employee relationship and customer WOM behavior (Gremler et al., 2001), and long term satisfied customers are likely to engage in positive WOM (Bendapudi & Berry, 1997; File & Prince, 1992; Gremler et al., 2001).



### ***Customer Satisfaction to Repurchase Intention***

Review of previous research in marketing, specifically in the foodservice industry, shows that satisfaction leads to repeat visits (Anderson & Sullivan, 1993; Johns & Pine, 2002; Kim, 2009; Kim & Ok, 2010). Results from a meta-analysis of fifty studies found strong correlation between customer satisfaction and repurchase intention (Szymanski & Henard, 2001), which further suggests the importance of satisfaction for consumer's repurchase intentions. Thus, it seems prudent to also hypothesize that consumer satisfaction, achieved through service employee's customer orientation and subsequent relational benefits, would lead to positive behavioral intentions, specifically repurchase intentions.

**H9:** Satisfaction has a positive effect on repurchase intentions.

### ***Customer Satisfaction to Word-of-Mouth***

Service firms are especially likely to be benefited from WOM and personal sources of information because they rely on their customers to advocate, provide referrals, and bring new customers (Bendapudi & Berry, 1997; eMarketer, 2010; Gremler & Gwinner, 2000; Gremler et al., 2001). Older adults are particularly accepting of personal sources of information (Cavanaugh, 2003; ARAMARK, n.d.), and both family and friends often influence them when they decide to enter a CCRC (ARAMARK, n.d.).

Previous studies show customer-to-employee interpersonal relationships lead to WOM (e.g., Gremler & Gwinner, 2000; Gremler et al., 2001), and that satisfactory contacts between employee and customer lead to positive WOM (Sundaram et al., 1998). Customer satisfaction also influences customer WOM behavior (Gremler et al., 2001). Additionally, satisfied customers are more likely to advocate the service. Thus, the following hypothesis was advanced:

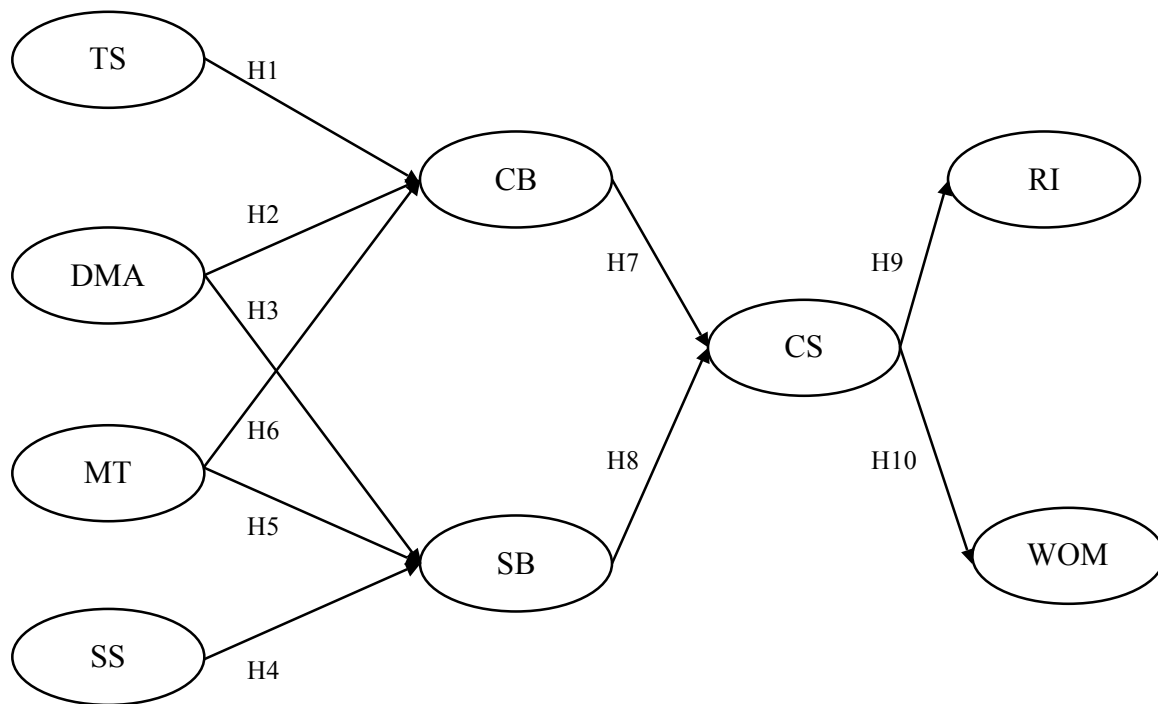
**H10:** Satisfaction has a positive effect on word-of-mouth communications.

## **The Proposed Model**

The hypothesized model of this study examines the relationships among the dimensions of customer orientation of service employees (COSE), relational benefits, and their effect on residents' satisfaction with foodservice facility and the subsequent behavioral outcomes (Figure 4.1). The conceptual model indicates that CCRCs' dining services in which the employees are perceived to be customer-oriented receive positive response from residents. First, the more residents perceive COSE, the more they perceive confidence benefits and social benefits in their

relationship with the restaurant. Second, increased perception of relational benefits positively affects customer satisfaction, which in turn enhances customers' repurchase intentions and word-of-mouth communications.

**Figure 4.1** Conceptual Model for First-Order Dimensions of COSE, Relational Benefits, Customer Satisfaction and Behavioral Intentions



*Note.* TS = technical skills; DMA = decision-making authority, MT = motivation, SS = social skills, CB = confidence benefits; SB = social benefits; CS = customer satisfaction; RI = repurchase intention; WOM = word-of-mouth intention.

## Methodology

Data were collected from independent and assisted living CCRC residents who frequently consume meals at campus dining establishments. Facility administrators and/or foodservice directors of the selected facilities were first contacted to ascertain their eligibility and interest in the study. CCRCs with on campus dining facilities that employ wait staff (e.g., restaurant style) were eligible for this study. A total of five facilities were included in this study. The names and information of the facilities were initially taken from the directory of CCRCs on LeadingAge (formerly American Association of Homes and Service for the Aging [AAHSA]) and Commission on Accreditation of Rehabilitation Facilities (CARF) International.

Information regarding the survey was advertised in the facility's newsletter, television, and/or research flyers to encourage participation among the residents prior to the distribution of the questionnaires. Survey packets that included the questionnaire and cover letter in a prepaid envelope (addressed to the researcher) were distributed through the residents' mailboxes. A total of 412 (47.5% response rate) completed questionnaires were returned to the researcher. The majority (65.3%) of the questionnaires were returned by mail. Just over one-third of the questionnaires were collected from facilities A, C, D, and E within two weeks of the initial distribution of the survey packets.

### **Data Analyses and Results**

Statistical analyses were performed using SPSS Statistics 20 (IBM Corporation, Armonk, NY) and AMOS 20 (IBM Corporation, Armonk, NY). Prior to data analyses, dependent and independent variables were examined for accuracy of data entry, missing values, and outliers. As the questionnaire consisted of multi-item scales with three measurement items for each construct, questionnaires with full responses or one missing value were included for further analysis. Missing value analysis (MVA) revealed variables used in this study were missing completely at random (MCAR). Missing values were replaced with the case's construct mean. Initial results of the confirmatory factor analysis revealed five cases as having multivariate outliers, which were subsequently removed. Thus, a total of 354 cases were subsequently used for further analysis.

### ***Characteristics of Facilities***

To be considered in the present study, a facility must have independent and assisted living accommodations with 50 or more residents and on-site dining facility with wait staff. Moreover, the CCRC must operate at least one full service restaurant that is open to all residents (independent, assisted, healthcare), in addition to other external patrons (e.g., family members or general public). Although these facilities welcome external visitors to their dining venues, these operations have never advertised externally as they are mostly not for profit operations.

Table 4.1 shows the profile of the five facilities selected in this study. Each facility operates restaurant-style dining rooms for their assisted living residents. A variety of dining options such as full service restaurant, café or bistro are open to all residents; however, independent living residents most often visit these venues.

Meal plans for the residents in all five facilities were similar with slight modifications between facilities for the independent living residents. Facility A offers a meal credit system with \$150 to be spent on meals at the restaurant or other things throughout the facility (e.g., grocery from the facility's kitchen). Independent living residents of facility B who frequent the restaurant need to pay cash for their meals (average meal is \$8.00). Facility C and D offers meal plans that is included in the residents' monthly due; two meals per day and 30 meal credits per month (to be used for lunch or dinner) respectively. Finally, independent living residents of facility D are given one meal per day for their meal plan. For the assisted living residents, all five facilities offer three meals per day. These meal plans are included in the residents' monthly dues.

**Table 4.1** Profile of Facilities

Facility	Available Dining Venues <sup>1</sup>	Meal Plan	Residents <sup>2</sup>
Facility A	Full Service Restaurant Café Pub & Lounge	Meal plan credit system	234
Facility B	Full Service Restaurant	Meal plans included in monthly dues <sup>3</sup>	189
Facility C	Full Service Style Dining Buffet Style Dining	Meal plans included in monthly dues <sup>4</sup>	143
Facility D	Full Service Restaurant	Meal plans included in monthly dues <sup>5</sup>	131
Facility E	Full Service Restaurant (3) Bistro	Meal plans included in monthly dues <sup>6</sup>	570

*Note.* Participants were residing in independent and assisted living units of these facilities.

<sup>1</sup> All facilities operate restaurant-style dining rooms for assisted living residents. Restaurants, cafés, or bistro are open to all residents; however, most visited by independent living residents.

<sup>2</sup> Include the number of independent and assisted living residents only.

<sup>3</sup> Three meals per day for assisted living residents and cash payment for independent living residents.

<sup>4</sup> Three meals per day for assisted living residents and two meals per day for independent living residents.

<sup>5</sup> Three meals per day for assisted living residents and a total of 30 meal credits for independent living residents.

<sup>6</sup> Three meals per day for assisted living residents and one meal a day for independent living residents.

### *Characteristics of Respondents*

Older adults aged 65 years and older were invited to participate in the study. The majority (n=194) of the respondents were 85 years and older. The mean age of respondents in this study is 85.4 years. Table 4.2 summarizes the demographic profile of the survey respondents in this study. Of the 354 respondents in the study, 69.8% were female (n=247) and 28.0% (n=99) were male.

Similar to the CCRC participants in other studies (cf. ARAMARK Senior Living Services, n.d.; Seo & Shanklin, 2005b; Stacey-Konnert & Pynoos, 1992), the participants in this study were highly educated. More than half of respondents had completed at least 4-year college

degree (n=193). Of those with college degrees, about a third (33.3%; n=117) of them have either had some graduate work or completed higher levels of education including masters and PhD.

The largest number of the respondents (44.1%) was from facility E with n=156 and the smallest number of responses came from facility D n=29 (8.2%). Facilities A, B, and C had similar number of participants 54, 60, and 55 respectively accounting for 47.7% of the overall responses.

**Table 4.2** Demographic Profile of Survey Respondents

Sample Characteristics	Frequency (n=354)	Percent (%)
Gender		
Male	99	28.0
Female	247	69.8
No response	8	2.3
Age		
65 – 74	13	3.7
75 – 84	133	37.6
85 or older	194	54.8
No response	14	4.0
Level of Education		
Less than high school	7	2.0
High school	62	17.5
2-year college	82	23.2
4-year college/university	76	21.5
Some graduate work	26	7.3
Graduate degree(s)	91	25.7
No response	10	2.8
Marital Status		
Single	10	2.8
Married	150	42.4
Divorced/separated	11	3.1
Widowed	175	49.4
No response	8	2.3
Type of Accommodation/Lifestyle		
Independent living	319	90.1
Assisted living	26	7.3
No response	9	2.5
Self-Perceived Health Status		
Poor health	34	9.6
Good health	277	78.2
Very best of health	34	9.6
No response	9	2.5

*Note.* Percentage values may not add up to 100% due to rounding numbers.

### ***Full Measurement Model***

The two-step approach as discussed by Anderson and Gerbing (1988) was used in this study. First, confirmatory factor analysis (CFA), using AMOS 20, was first applied as a preliminary analysis to evaluate the convergent and discriminant validity of the measurement items that connect to corresponding latent variables simultaneously. Second, a structural model that specifies the causal relations of the constructs to one another was evaluated.

Results of the CFA indicated that the overall fit of the initial measurement model was satisfactory except for chi-square (RMSEA = .067, CFI = .946, TLI = .935, IFI = .947;  $\chi^2_{(288)} = 739.3, p < .001$ ) (Byrne, 2001). Modification indices suggested that improvement to the model fit could be achieved by allowing some of the measurement error terms to correlate. The final measurement model presented a very good fit with the data (RMSEA = .057, CFI = .961, TLI = .952, IFI = .962;  $\chi^2_{(283)} = 609.3, p < .001$ ), except for chi-square which indicated that the likelihood of relations as summarized in the measurement model occurring less than one time in a thousand under the null hypothesis and should be rejected (Byrne, 2001). However, chi-square is often reported as significant because of sample size and strict assumptions (Bagozzi & Yi, 1988; Byrne, 2001).

### ***Reliability and Validity***

Convergent validity was evaluated by indicator loadings. Table 4.3 reports the standardized loadings of scale items used in this study. As presented in the table, the full measurement model consisted of nine constructs and 27 measurement items. All factor loadings of manifest variables on their respective latent variables were greater than .70 except three and significant at the level of .001, satisfying convergent validity criteria (Anderson & Gerbing, 1988). One technical skills item and two social benefits items had standardized loadings close to the ideal .70. As such, those items were kept for further analyses.

Table 4.4 presents the descriptive statistics, composite reliabilities, correlations, and squared correlations of the variables analyzed in the study. Composite reliabilities of constructs ranged from .77 to .95, exceeding the conventional cutoff point of .70 (Fornell & Larcker, 1981). The average variance extracted (AVE) of constructs were higher than .50, demonstrating that more than half of the variances in the constructs are explained by their corresponding measures (Fornell & Larcker, 1981; Hair et al., 2010).

Discriminant validity is satisfied if  $R^2$  between a pair of constructs is less than the AVE for each corresponding construct (Fornell & Larcker, 1981). Discriminant validity was confirmed for all constructs except for five pairs of constructs: technical skills and social skills, technical skills and decision-making authority, technical skills and confidence benefits, social skills and motivation, social skills and social benefits (Table 4.4). The  $\chi^2$  difference test was carried out on each pair of the potentially correlated constructs by combining the two constructs as one (Anderson & Gerbing, 1988). To satisfy the discriminant validity criterion, the fit of the newly combined model should be significantly better than the fit of the original model with a critical chi-square value of 3.84 ( $df = 1$ ). The chi-square statistics of the newly combined models for technical skills and social skills, technical skills and decision-making authority, technical skills and confidence benefits, social skills and motivation, social skills and social benefits were  $\Delta\chi^2(8) = 140.5$ ,  $\Delta\chi^2(8) = 90.3$ ,  $\Delta\chi^2(8) = 142.3$ ,  $\Delta\chi^2(8) = 65.5$ , and  $\Delta\chi^2(8) = 86.3$  respectively. The  $\chi^2$  differences of five models were more than the suggested values at  $\Delta\chi^2(8) = 26.13$ ; therefore, discriminant validity was established.

**Table 4.3** Confirmatory Factor Analysis: Items and Standardized Loadings

Construct and Scale Items	Standardized Loadings
<b>Technical Skills</b> (Hennig-Thurau, 2004) Based on all my experiences, a typical employee of this restaurant... ...has adequate knowledge of the menu, recipes, and ingredients. ...is expert in serving customers. ...is highly competent in performing his/her job	.674 .871 .907
<b>Social Skills</b> (Hennig-Thurau, 2004) Based on all my experiences, a typical employee of this restaurant... ...is always friendly and courteous. ...is able to consider their customers' perspectives. ...knows how to treat a customer well.	.707 .801 .864
<b>Motivation</b> (Hennig-Thurau, 2004) Based on all my experiences, a typical employee of this restaurant... ...shows strong commitment to their job. ...does their best to fulfill my needs. ...is always highly motivated.	.872 .835 .919
<b>Decision-Making Authority</b> (Hennig-Thurau, 2004) Based on all my experiences, a typical employee of this restaurant... ... is allowed to decide freely in customer matters. ...has authority to take action in solving customer matters. ...does not need to ask their supervisor for permission in the case of customer requests.	.855 .836 .759
<b>Confidence Benefits</b> (Gwinner et al., 1998) Based on all my experiences with this restaurant... ...I believe there is less risk that something will go wrong. ...I have more confidence the service will be performed correctly. ...I have less concern when I buy the service.	.779 .878 .763
<b>Social Benefits</b> (Gwinner et al., 1998) Based on all my experiences with this restaurant... ...I am recognized by certain employee(s). ...they know my name. ...I enjoy certain social aspects of the relationship.	.677 .695 .801
<b>Customer Satisfaction</b> (Hennig-Thurau et al., 2003; Cronin et al., 2000) Considering my experiences with this restaurant... ...I am very satisfied with the dining services it provides. ...my choice to patronize this restaurant was a wise one. ...overall, I am satisfied with the decision to patronize this restaurant.	.861 .956 .949
<b>Repurchase Intention</b> (Hellier et al., 2003; Cronin et al., 2000) All things considered, as long as the present service continues... ...I would keep dining out at this restaurant in the future. ...I would dine out at this restaurant at least at current frequency in the future. ...it is very likely that I will dine out at this restaurant again.	.957 .841 .774
<b>Word-of-Mouth Intention</b> (Gremler & Gwinner, 2000) Thinking of my relationship with this restaurant... ...I would recommend this restaurant whenever anyone seeks my advice. ...I go out of my way to recommend this restaurant, when the topic of restaurants comes up in conversation. ...I have actually recommended this restaurant to my friends.	.945 .849 .829

Note. All factor loadings were significant at  $p < .001$ .



**Table 4.4** Descriptive Statistics, Composite Reliabilities, Correlations, and Squared Correlations

	Mean (SD)	AVE	TS	DMA	MT	SS	CB	SB	CS	RI	WOM
TS	3.99 (.74)	.68 <sup>c</sup>	<b>.86<sup>a</sup></b>	.83 <sup>b</sup>	.81	.85	.82	.71	.62	.56	.63
DMA	3.90 (.82)	.67	.69	<b>.86</b>	.78	.67	.72	.62	.54	.52	.57
MT	4.33 (.69)	.77	.66	.61	<b>.91</b>	.90	.79	.68	.63	.59	.62
SS	4.42 (.61)	.63	.72	.45	.81	<b>.83</b>	.80	.77	.67	.62	.64
CB	4.11 (.70)	.65	.67	.52	.62	.64	<b>.85</b>	.68	.74	.71	.69
SB	4.44 (.61)	.53	.50	.38	.46	.59	.46	<b>.77</b>	.69	.72	.59
CS	4.32 (.77)	.85	.38	.29	.40	.45	.55	.48	<b>.95</b>	.85	.78
RI	4.51 (.63)	.74	.31	.27	.35	.38	.50	.52	.72	<b>.89</b>	.72
WOM	3.98 (.93)	.77	.40	.32	.38	.41	.48	.35	.61	.52	<b>.91</b>

Note. AVE = average variance extracted; TS = technical skills; DMA = decision-making authority, MT = motivation, SS = social skills, CB = confidence benefits; SB = social benefits; CS = customer satisfaction; RI = repurchase intention; WOM = word-of-mouth intention.

<sup>a</sup> Composite reliabilities are along the diagonal in bold.

<sup>b</sup> Correlations are above the diagonal.

<sup>c</sup> Squared correlations are below the diagonal.

### ***Structural Model and Relationship Tests***

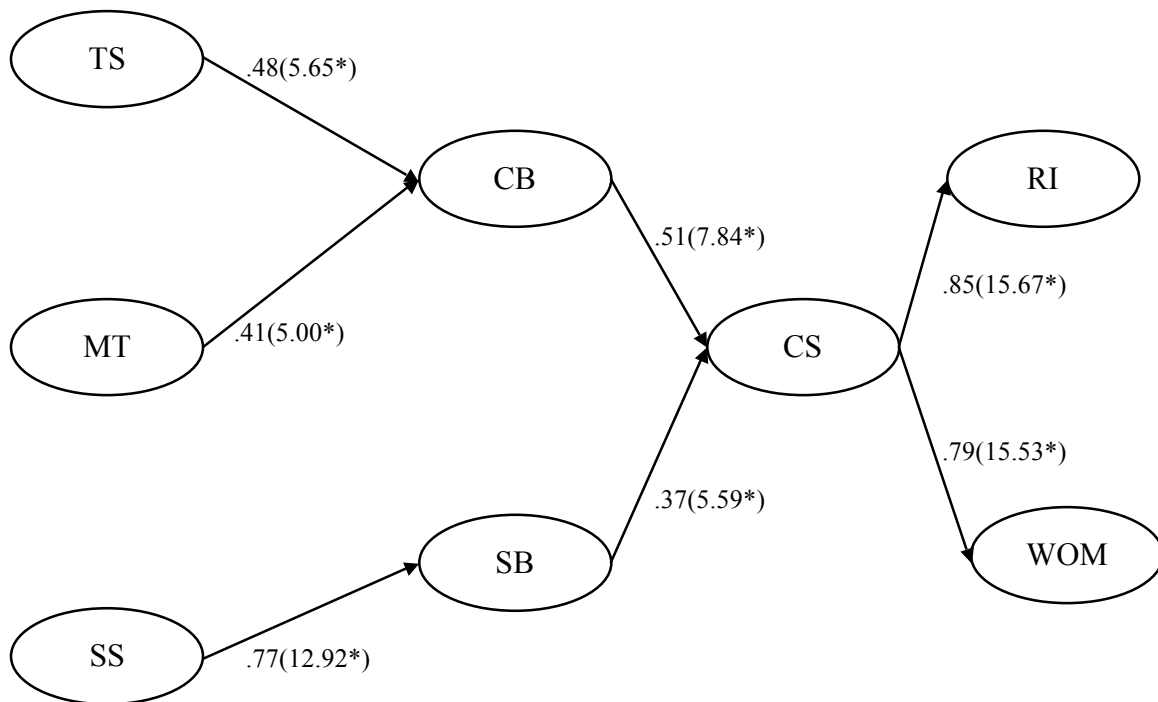
To test the full structural model that includes both the measurement model and the structural model that proposes the hypothesized relationships among the variables, the initially proposed model was tested using structural equation modeling analysis. Then the initial model was revised based on the modification indices in the output. Overall fit indices for the proposed model presented an acceptable fit with the data (RMSEA = .059, CFI = .956, TLI = .949, IFI = .956;  $\chi^2_{(303)} = 672.1, p < .001; \chi^2/df = 2.22$ ).

However, several non-significant ( $p > .05$ ) paths emerged, namely the paths from DMA to CB, DMA to SB, and MT to SB. The construct DMA and the path from MT to SB were subsequently removed. The model fit for the final structural model revealed a significantly improved fit to the data  $\Delta\chi^2 = 193.0, \Delta df = 65, p < .001$  (RMSEA = .054, CFI = .968, TLI = .962, IFI = .968;  $\chi^2_{(238)} = 479.1, p < .001; \chi^2/df = 1.99$ ). Figure 4.2 presents the final structural model with path coefficients and *t*-values.

The results of this study revealed that different dimensions of COSE affected residents' perceptions of social and confidence benefits. TS and MT both positively affected CB ( $\beta = .48, p < .001$ , H1 supported, and  $\beta = .41, p < .001$ , H3 supported respectively). However, no relationship was found between DMA and CB (H2 rejected). Residents' perception of employee's SS was the only dimension that had a significant positive impact on SB ( $\beta = .77, p < .001$ , H4 supported). However, MT and DMA both had no relationships with SB (H5 and H6 rejected respectively).

The current study also revealed CB ( $\beta = .51, p < .001$ ) and SB ( $\beta = .37, p < .001$ ) to positively affect CS (H7 and H8 supported). Furthermore, CS positively affected RI ( $\beta = .85, p < .001$ , H9 supported) and WOM ( $\beta = .79, p < .001$ , H10 supported). Table 4.5 summarizes the results for hypotheses forwarded in this study.

**Figure 4.2** Results of the Revised Model



*Note.* TS = technical skills; DMA = decision-making authority, MT = motivation, SS = social skills, CB = confidence benefits; SB = social benefits; CS = customer satisfaction; RI = repurchase intention; WOM = word-of-mouth intention.

<sup>\*</sup> $p < .001$

<sup>1</sup>Number in parentheses are the t-values.

<sup>2</sup>Number outside parentheses are the standardized path coefficients.

**Table 4.5** Summary of Hypotheses Tests.

	Hypothesis	Result
H1	Resident's perception of employee's TS have a positive effect on CB	Supported
H2	Resident's perception of employee's DMA has a positive effect on CB	Rejected
H3	Resident's perception of employee's MT has a positive effect on CB	Supported
H4	Resident's perception of employee's SS have a positive effect on SB	Supported
H5	Resident's perception of employee's MT has a positive effect on SB	Rejected
H6	Resident's perception of employee's DMA has a positive effect on SB	Rejected
H7	CBEN have a positive effect on CS	Supported
H8	SBEN have a positive effect on CS	Supported
H9	CS has a positive effect on RI	Supported
H10	CS has a positive effect on WOM	Supported

*Note.* TS = technical skills; DMA = decision-making authority, MT = motivation, SS = social skills, CB = confidence benefits; SB = social benefits; CS = customer satisfaction; RI = repurchase intention; WOM = word-of-mouth intention.

## Discussion and Implications

The findings of this study have several practical implications. The results provide a way for CCRCs to stimulate residents' satisfaction with dining services and subsequently improve residents' repeat purchases; in addition, increasing the likelihood of current residents advocating, providing referrals and bringing in new residents and/or customers to the facility. The development of interpersonal relationships between employees and residents through customer orientation behaviors and relational benefits can improve residents' satisfaction with service that, in turn, will improve the success and longevity of the dining services in particular and also the CCRC facility in general.

The conceptualization of the COSE provides concrete information for management looking to improve a service firm's customer orientation (Hennig-Thurau & Thurau, 2003). The current study examined the relationships between specific dimensions of COSE: technical skills, social skills, decision-making authority, and motivation with confidence benefits and social benefits. The results revealed that employee's technical skills and motivation to be salient to residents' perceptions of confidence benefits while only employee's social skills were important to residents' perception of social benefits. Contrary to the researcher's initial hypotheses, decision-making authority did not have a significant impact on both confidence and social benefits.

### ***Practical Implications***

The findings support the main contention of this study that the customer orientation of individual service employees enhances residents' perception of relational benefits in their relationship with the service employees and ultimately contributes to residents' long-term relationship with the restaurant. This study revealed that current CCRC residents who are satisfied with the dining services lead to positive repurchase intentions and word-of-mouth intentions. This is extremely beneficial for the CCRC because seniors often rely on informal sources of recommendation from family and friends on the choice of residential and aged care. Additionally, word-of-mouth is the single most believable and unbiased method of stimulating new business. As such, CCRCs should take advantage of the positive contribution of dining employees by enabling them to behave in a customer-oriented manner.

Most CCRCs practice resident-centered care, and practice a certain level of autonomy when it comes to residents' day-to-day care, this practice should also extend to the dining personnel. Dining employees have firsthand information regarding residents' food intake and socialization at mealtimes. These employees are likely to identify subtle behavioral changes that might be an indicator to underlying health related problems. As such, the facility's dining staffs need to be able to put residents' interest first, because they too contribute towards residents' general well-being, thus supporting the facility's objective of maintaining and/or improving residents' independence.

The importance of foodservice employees in CCRCs is no longer deniable. Relationships between service employees and residents developed through employees' customer orientation and relational benefits can improve residents' satisfaction with dining services. Residents' satisfaction in turn impacts their repurchase intentions and word-of-mouth communications.

### **Limitations and Suggestions for Future Study**

As with any study, some limitations should be acknowledged in the interpretation of findings. First, the data were collected at a single point in time as a cross-sectional study. Although causal relationships in this study were developed according to theoretical predictions and related literature, longitudinal research is encouraged for future study in order to confidently interpret the pattern of relationships revealed in this study.

Second, the samples and measurements may not generalize to the overall population of elderly residents in CCRCs. Data were collected from independent and assisted living residents from five facilities in the Midwest, specifically Kansas and Missouri. Furthermore, participants were homogenous in terms of gender, race/ethnicity, and type of living accommodation. Therefore, it is possible that certain values and opinions are shared within this group particularly. Future study may want to focus on more diverse samples to better generalize the results to the overall CCRC population with confidence. Additionally, by including residents from all three levels of care, comparison between the different groups can be conducted thus providing further insights into similarity and diversity of the groups.

Third, the potential for common method variance should be addressed for all self-reported measures used in this study (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003); however, according to Spector (2006) the problem may be overstated. Future study may consider using multimethod data collection procedure such as including both quantitative and qualitative data.

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## **Chapter 5 - The Roles of Interpersonal Relationship and Dining-Need Satisfaction on CCRC Residents' Quality of Life**

### **Abstract**

Better health and improved life expectancy has greatly increased the number of seniors worldwide. The increase in the number of older Americans aged 65 years and older almost doubled in comparison to the number of under-65 population since 2000. Older population represented 13.1% (equivalent to 40.4 million) of the total U.S. population in 2010. The change in the U.S. sociodemography has fueled the need for affordable housing and personal care for the elderly. Continuing care retirement communities (CCRCs) offer an array of housing and healthcare options for seniors. Concern over the quality of life of elderly residents has resulted in a culture change that practices resident-centered care. By providing services and options that accommodate to senior residents' changing needs over time continuing care retirement communities are better equipped to achieving the objective of aging in place. Implicit to this philosophy is the emphasis on quality of service and quality of life of residents. This study explored the moderating effects of resident's activity involvement and food involvement on the relationships between rapport, dining-need satisfaction and resident's quality of life. To achieve the objective of this study, data were collected from 412 CCRC residents in five facilities. Results of hierarchical multiple regressions revealed that rapport and dining-need satisfaction have positive effects on resident's quality of life. These relationships are further magnified by resident's activity involvement and food involvement.

*Keywords:* rapport; dining-need satisfaction; activity involvement; food involvement; quality of life (QOL); continuing care retirement communities (CCRCs); dining services

## Introduction

Improved health, increased life expectancy, and decreased fertility rate globally have resulted in the overarching trend of aging that threatens to inundate the world's healthcare systems and sweep away today's social, political, and economic norms or what researchers coined as the "gray tsunami" (Wheelwright, 2012). The U.S. population is not free from the grasps of this global phenomenon. The American elder population is increasing at a rate faster than the under-65 population (Administration on Aging [AoA], 2011), with persons reaching age 65 having an average life expectancy of 18.8 years (20.0 years for females and 17.3 years for males) (AoA, 2011). The rapid growth of the elderly population and the demand for a modest (cost-effective) alternative to nursing home care has fueled the growth of assisted living facilities and continuing care retirement communities (CCRCs) (Cummings, 2002).

Contrary to other senior living communities, CCRCs commonly practice the aging in place philosophy by providing a spectrum of housing that coincides with resident's personal needs and health status (American Association of Homes and Services for the Aging [AAHSA], 2008; Assisted Living Federation of America [ALFA], 2009; Position of the American Dietetic Association [ADA], 2000). CCRCs offer three options for housing: *independent living* for still-healthy independent residents, *assisted living* for residents in need of some help with daily activities, and *nursing* or *healthcare* for residents requiring higher level of health and personal care.

Concern over the quality of life (QOL) of elder residents has resulted in a culture change that practices personalized resident-centered care (ALFA, 2009; Doty, Koren, & Sturla, 2008). In addition to adapting to residents' need for primary health care, residents can opt for the facility's personal care option (bathing, dressing, toileting, transferring, and eating), as well as the social, cultural, and educational programs.

Mealtime is often the highlight of the day for both psychological and physiological reasons for the residents (Ball et al., 2000; Cluskey, 2001a, 2001b; Seo & Shanklin, 2005a). In fact, food has been found to be a predictor of residents' QOL (e.g., ADA, 2000; Crogan, Evans, Severtsen, & Shultz, 2004; Lengyel, Smith, Whiting, & Zello, 2004; Seo & Shanklin, 2005). Dining services in CCRCs facilitate residents' enjoyment of food and provide social interaction

opportunities that contribute to the quality of life for older adults (Cluskey, 2001a, 2001b; Seo & Shanklin, 2005b).

Research exploring the potential contribution of employee-to-resident relationship on resident's QOL is scarce although researchers acknowledge that mealtimes provide excellent opportunities for residents to develop relationships with service employees (Ball et al., 2000; Cluskey, 2001a). The interpersonal realm, being compassionate, caring, and having good relationships, is essential to older adults (Ryff, 1989). For retirees, both activities and community participation are associated with greater quality of life and a more positive well-being (Heisler, Evans, & Moen, 2004; p. 9).

This study fills the gap in the literature by exploring employee-to-resident rapport and residents' dining-need satisfaction as potential predictors of residents' QOL. Further, the moderating roles of activity involvement and food involvement are also examined.

## **Theoretical Background and Hypotheses**

### ***Quality of life***

QOL is central to many senior living facility studies (e.g., Ball et al., 2000; Crogan et al., 2004; Cummings, 2002; Jenkins, Pienta, & Horgas, 2002; Kane, 2001). However, researchers have yet to reach an agreement on the definition of QOL, though studies have used many dimensions to qualify it (cf. ADA, 2000; Ball et al., 2000; Crogan et al., 2004; Kane, 2001; Lengyel et al., 2004; Seo & Shanklin, 2005a). Psychological well-being (Ball et al. 2000), social relations and interaction (Ball et al., 2000; Kane, 2001; Seo & Shanklin, 2005a), meaningful activity (Ball et al., 2000; Kane 2001) are among the domains of QOL. Several studies have pointed to food and good nutrition as salient QOL indicator for residents in senior living settings (e.g., ADA, 2000; Crogan et al., 2004; Lengyel et al., 2004; Seo & Shanklin, 2005a).

Activity engagement, particularly *active* activity is related to better QOL (Jenkins et al., 2002). Residents who participate in recreational activities, hobbies, socializing with friends, and taking walks or exercise have higher health-related QOL ratings. Furthermore, inactivity (time spent doing nothing) is inversely related to QOL. Although recreational activity can be a platform for socialization, most CCRC residents, following their move reported ease of meeting and making friends (Heisler et al., 2004).

The positive effect of social relationships on mental health is generally understood (Hinson Langford et al., 1997; Kawachi & Berkman, 2001). One reason for moving into care facilities is to be around people (Ball et al., 2000). Several studies have suggested that social support might protect seniors from negative physical health and mental health outcomes (Cummings, 2002; Potts, 1997). According to Ball et al. (2000), residents typically have three types of valued relationships: 1) family and friends outside the facility, 2) other residents, and 3) their formal caregivers. One group often unmentioned in the literature on senior living facilities is the foodservice. These employees can usually interact with resident patrons of the foodservice establishments. In fact, Cluskey (2001b) reported that foodservice employees could identify subtle behavioral changes indicating the onset of Alzheimer's disease and symptoms of heart attacks or strokes for which early detection can make a difference. Clearly, service employees are essential to the well-being of residents.

### ***Rapport***

Rapport is defined as a "customer's perception of having an enjoyable interaction with a service provider employee, characterized by a personal connection between the two interactants" (Gremler & Gwinner, 2000, p. 92). According to the authors *enjoyable interaction* is a cognitive evaluation of the employee-customer interaction, while *personal connection* is the affiliation that the two individuals may have resulting from similarities or shared experiences.

Studies on rapport have been conducted over the years (e.g., DeWitt & Brady, 2003; Gremler & Gwinner, 2000; Gremler & Gwinner, 2008; Kim & Ok, 2010; Kim, Ok, & Gwinner, 2010). Many of these studies have indicated the importance of rapport in developing relationships and customer satisfaction. Gremler and Gwinner (2000) found that both enjoyable interaction and personal connection were significantly related to satisfaction, loyalty intention, and word of mouth communication among bank customers. Kim and Ok (2010) found rapport leads directly to customer satisfaction and affective commitment, while indirectly affecting repurchase intention through affective commitment.

The characteristic of a service encounter is such that the employee and the customer must interact with one another (Bitner, Faranda, Hubbert, & Zeithaml, 1997). The role of a service provider during the service encounter is important because it is the first moment in which service occurs (Bitner, Booms, & Mohr, 1994). This interaction provides an opportunity for socialization

(Price & Arnould, 1999) and the service provider's friendliness and perceptions of similarity achieved over time contribute towards the development of a relationship (Bitner et al., 1997). Furthermore, services are predominantly performances in which service employees shape the service experience (Bendapudi & Berry, 1997). However, customers also play a critical role in service creation and their own level of satisfaction (Bitner et al., 1997),

In a service setting, functional conversation on service delivery is common; however, for a relationship to ensue between employee and customer, behaviors such as transaction-irrelevant conversation, disclosure, and helping need to be present (Goodwin, 1996), akin to the enjoyable interaction and personal connection proposed by Gremler and Gwinner (2000). For this to be possible, four characteristics of service delivery situation (conversation time, self-disclosure, physical environment, duration of relationship) could influence the perception of relationship (Goodwin, 1996).

In a CCRC, the possibility of the same customer or resident patronizing the foodservice establishment is high. In some CCRCs, residents are a 'captured audience' because residents in these facilities have paid for meals as part of their monthly dues. In fact, Cluskey (2001a; 2001b) found mealtimes for CCRC residents were a wonderful opportunity for socialization with the wait staff and other residents. Therefore, the same residents and service provider would likely interact frequently. Frequent interaction, service provider friendliness, and perceived similarity would lead to rapport; combined with the residents' general need for more socialization and interaction would lead to improved QOL. Therefore, this hypothesis is forwarded.

**H11:** Rapport has a positive effect on quality of life.

### ***Dining-Need Satisfaction***

The construct dining-need satisfaction answers the question: What individual's need would consuming food and dining satisfy? People consume food for a variety of reasons. The hierarchy of needs theory identifies food as a basic physiological need. The primal purpose of consuming food is to satisfy hunger. Any type of food and beverage would fulfill this basic need. Food is the only product category that is consumed for both survival and nutritive purposes.

Nutritional attributes of food and beverage reinforce health and well-being contributing to the quality of life of older adults (ADA, 2000; Ball et al., 2000; Chao & Dwyer, 2004; Cluskey, 2001a; 2001b; Crogan et al., 2004; Lengyel, et al., 2004). "Proper nutrition prevents

health problems; it can improve health, help avert impairments in functional status, and increase quality of life and well-being in older adults” (Amarantos, Martinez, & Dwyer, 2001; p. 57). Furthermore, inadequate nutrition results in malnutrition, morbidity, and mortality (Lengyel et al., 2004).

In addition to the nutritional aspect of food and beverage, the sensory, psychological, and social aspects of food and eating must also be considered (Amarantos, Martinez, & Dwyer, 2001). Eating is among the most important components of an elderly person’s daily life (ADA, 2000); therefore it should receive the attention it deserves. Variety in taste, texture, and type of food should be considered in preparing food for the elderly. A few studies have demonstrated that satisfaction with food services was associated with quality of life (e.g., Lengyel et al., 2004). Specifically, residents responded well to appropriate timing, variety on special occasions, amount or portion size, temperature of cold food, and service during mealtimes. These findings were similar to other food, nutrition, and dining services studies among the elderly (e.g., Lee et al., 2003; Seo, 2005; Seo & Shanklin, 2005b).

Multiple dimensions influence a meal experience (Andersson & Mossberg, 2004; Gustafsson, Öström, Johansson, & Mossberg, 2006). Findings in Andersson and Mossberg (2004) showed food as the basic requirement to fulfill the basic need for hunger, but an ideal meal would include additional satisfiers like *service, fine cuisine, restaurant interior, good company, and other customers*. The study found that customers were willing to pay more for an ideal meal than a basic meal. The Five Aspect Meal Model (FAMM) discussed in Gustafsson et al. (2006) revealed five aspects (i.e., *room, meeting, products, management control systems, and atmosphere*) that managers of foodservice establishments must consider. Lengyel et al. (2004) noted that food service delivery should occur in an environment that fosters autonomy, interpersonal relations, and security. Research shows socialization or social relationships are also critical for older adults (cf. Hinson Langford, Bowsher, Maloney, & Lillis, 1997; Kawachi & Berkman, 2001), not only among residents within a CCRC, but with people outside the community (Stacey-Konnert & Pynoos, 1992).

According to Jhaveri (2006), seniors prefer an environment with intergenerational interaction to keep from feeling isolated from the world at large. Cluskey (2001b) noted that interpersonal relationships develop between residents and wait staff, which could fulfill the need for socialization. It also presents an opportunity for residents to have a link to the world at large

because employees live outside the retirement community with the general population. Thus, the fourth construct of dining-need satisfaction is socialization.

Following this line of argument, an individual's food and dining needs include food and beverage to satisfy hunger, nutritional need, and sensory need (taste/flavor, texture, temperature etc.), but also the need for socialization. In this study, the author hypothesizes a positive relationship between residents' quality of life and their dining-need satisfaction. That is, residents whose food/dining needs are fulfilled will also report better quality of life.

**H12:** Food-need satisfaction has a positive effect on quality of life.

### *Activity Involvement*

Social relationships are important to older adults. Research generally agrees on the connection between social ties and mental health (cf. Gilbert & Hirdes, 2000; Hinson Langford et al., 1997; Kawachi & Berkman, 2001). CCRC residents may develop social relationships with other residents through activities within the facility. More engaged older adults are more likely to have social support during stressful or difficult life events (Hinson Langford et al., 1997). Social support makes it even more likely for an older adult to recover after an injury or illness than those without social support.

Older adult's QOL is affected by their physical activity, social interaction, nutritional well-being, health, independence, and physical functioning (ADA, 2000). Active participation by older adults in planning and implementing new policies and programs is a way to ensuring their own needs are met (Stacey-Konnert & Pynoos, 1992). Although the real advantage of living in a CCRC may be the potential to converse with people, a few respondents (6% or 3 respondents) reported that they did not have relationships with others within the CCRC (Stacey-Konnert & Pynoos, 1992). Those with health issues, cognitive deficiency, care-giving responsibility, a history of social isolation, the very old, and some widows tend to be socially inactive. These individuals are more likely to have mental health problems as a result of isolation from others.

Gilbert and Hirdes (2000) conducted a study among institutionalized older adults and found social engagement consistently predicted psychosocial well-being (measured using happiness, emotionality, and mood indexes). According to the authors, the Index of Social Engagement had the most significant effect in all models, suggesting social engagement as the most important variable for explaining variation in well-being among residents. As a corollary to



these findings, we propose here that older adults' activities could have a positive effect on their QOL. Thus, the more involved or engaged an individual is in activities with others, the higher their QOL score.

### ***Moderating Effect of Activity Involvement***

Research has repeatedly shown that social interaction is crucial to elder adults' QOL and overall well-being (cf. Ball et al., 2000; Jenkins et al., 2002; Kane, 2001; Kawachi & Berkman, 2001; McGilton, 2002) and may protect seniors from health and mental issues. Residents willing to be involved in a facility's activities will have better QOL. Residents who are willing to be involved in a facility's activities will have better QOL. Highly activity involved residents will take advantage of any opportunity for social interaction. Such a resident would not only enjoy rapport with service employee, but also welcome any interpersonal interaction with them. Thus, it is proposed that rapport positively affects QOL, especially among socially engaged residents.

**H13:** Activity involvement moderates the relationship between rapport and quality of life.

### ***Food Involvement***

Consumer involvement is an individual difference variable; it is a causal or motivating variable with consequences for consumer purchases and communication behavior (Laurent & Kapferer, 1985). The extent of consumer's decision process and information search depends on the level of their involvement. Bloch (1981) has defined involvement as an ongoing interest, arousal or emotional attachment to the product in a particular individual (Bloch, 1981; Ladki & Nomani, 1996). According to Bloch, involvement varies across individuals, ranging from minimal levels to the extremely high levels. In line with this definition, Ladki and Nomani (1996) defined an active (highly involved) shopper as "a consumer who spends resources in the acquisition of information related to the product prior to purchase" (p. 18). On the other hand, passive shoppers not only expend little effort searching for information before a purchase, they also depend heavily on WOM in purchase decision-making.

Traditionally, food as a product category is considered low involvement because of the low cost of food relative to total income (Bell & Marshall, 2003). However, this may be true only for food purchased and consumed domestically (at home). Based on a review of related literature, the consumer decision process for food or meals consumed outside the home seems to differ from that for home food. Among a few studies on consumer involvement in restaurant

selection (e.g., Bloemer & Ruyter, 1999; Ladki & Nomani, 1996; Sun, 1995), full-service restaurant customers are highly involved in the service process (Bloemer & Ruyter, 1999). The authors also found a significant difference between consumer involvement with quick-service restaurants than full-service restaurants.

In selecting a restaurant, consumers invest time and money to acquire an intangible experience (Sun, 1995). The risk and cost invested may cause consumers to feel more strongly about the product. According to Bell and Marshall (2003), food choices have both social and health risks. Today's consumers seek restaurants that provide quality food and service at an equitable price/value (Sun, 1995).

Marketing and consumer behavioral studies focus on consumer involvement because of its positive outcomes. Ladki and Nomani (1996) found that among active consumers, psychological involvement (opinion, belief, and behavioral intention) correlated significantly with satisfaction. However, none of the psychological involvement dimensions correlated significantly with satisfaction among passive consumers. Kinard and Capella (2006) found consumer involvement level moderates the perceived relational benefits offered by the service provider; highly involved consumers perceived greater relational benefits than less involved consumers. Marshall and Bell (2004) reported on military personnel for whom meals were prepared and found higher levels of food involvement correlated with variety seeking, and highly involved individuals also tended to make healthier food choices.

Varki and Wong (2003) found that highly involved consumers showed more interest in establishing a relationship with service providers. Specifically, highly involved consumers of experiential service (e.g., long-distance telephone service) had a dedication-based or voluntary relationship, unlike consumers of credence service (e.g., general practitioner), who engaged in both dedication-based and constraint-based relationships. Consequently, we propose that residents would appreciate the rapport from engaging with the service employees, and this will lead to greater quality of life among highly involved resident consumers.

### ***Moderating Effect of Food Involvement***

Ladki and Nomani (1996) found a positive association between consumer involvement and consumer satisfaction. Highly food involved (active) consumers invest resources like time and effort to gathering information before the actual dining occasion. Thus, the active consumer

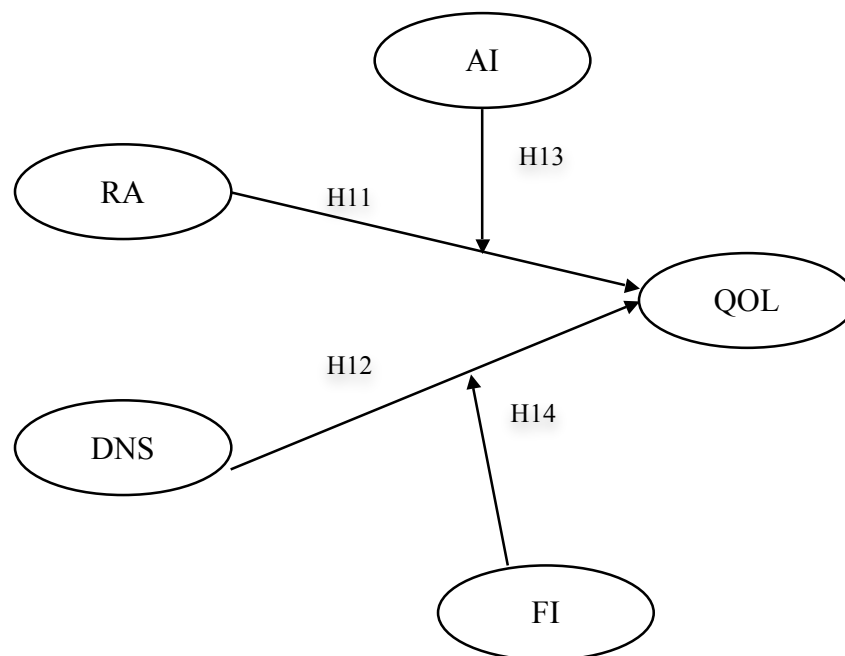
will have prior knowledge and, as a result, hold clearer expectations of the kinds of cuisine and service in the chosen establishment. When highly involved consumers invest resources that give them a more precise expectation of a service experience, they have more positive feelings with the outcome. Consequently, it is hypothesized that the effects of dining-need satisfaction on QOL is stronger for active/food involved consumers.

**H13:** Consumer involvement moderates the relationship between dining-need satisfaction and quality of life.

### The Proposed Model

In Figure 5.1, the hypothesized relationships are identified. The conceptual model indicates that employee-resident rapport and resident's dining-need satisfaction have positive effects on residents' quality of life. Further, these relationships will be further magnified among residents who have high activity involvement and food involvement.

**Figure 5.1** Conceptual Model



*Note.* RA = rapport; DNS = dining-need satisfaction; AI = activity involvement; FI = food involvement; QOL = quality of life.

## **Methodology**

### ***Procedures for Collecting Data***

LeadingAge and Commission on Accreditation of Rehabilitation Facilities (CARF) International provided the sampling frame for the study. CCRCs with on campus dining facilities that employ wait staff (e.g., full-service restaurant) were eligible. Facility administrators or foodservice directors of the selected facilities were first contacted to ascertain their eligibility and interest in participating in the study.

Upon approval from the facilities, information regarding the survey was advertised in the facility's newsletter, television station, and/or research flyers to encourage participation among the residents prior to the distribution of the questionnaires. Survey packets that consisted of a prepaid envelope (addressed to the researcher) with the cover letter and questionnaire were distributed through the residents' mailboxes. Four hundred and twelve (47.5% response rate) independent and assisted living residents who frequent on-campus dining establishments from five CCRCs in the Midwest participated in the present study.

### **Data Analyses and Results**

Statistical analyses were performed using SPSS Statistics 20 (IBM Corporation, Armonk, NY). Prior to data analyses independent and dependent variables were examined for accuracy of data entry, missing values, and outliers. Only complete questionnaires and those with one missing value were included for further analysis as the questionnaire consisted of multi-item scales. Missing values analysis (MVA) revealed variables used in this study were not missing completely at random (NMCAR). Subsequently, paired sample *t*-tests were conducted to compare between scores with missing values and scores with mean replacements. Results revealed no significant difference ( $p > .05$ ) between the scores. Initial results of the confirmatory factor analysis revealed five cases as having multivariate outliers, which were subsequently removed. A total of 354 cases were used for further analysis.

### *Characteristics of Facilities*

Five CCRCs with all three types of living accommodations (independent, assisted, nursing/healthcare) with 50 or more residents and on-site dining facility were included in the study. Moreover, the CCRC must operate at least one full-service restaurant that is open to all residents, in addition to other outside patrons (e.g., family members or general public). Although the dining venues also welcome non-resident patrons, these operations have never advertised externally due to the facility's not-for-profit status.

Table 5.1 presents the profile of the five facilities selected in this study. Each facility operates restaurant-style dining rooms for the assisted living residents. Several of the facilities operate multiple dining establishments; facility A operates a full service restaurant, café, and pub & lounge, facility C operates both full service and buffet style dining, and facility E (the largest of the five facilities) operates three full service restaurants and a bistro. Facilities B and D both operate a full service restaurant.

Meal plans for the residents in all five facilities were similar with slight modifications between facilities for the independent living residents. Facility A offers a meal credit system with \$150 to be spent on meals at the restaurant or other things throughout the facility (e.g., grocery from the facility's kitchen). Cash payment is required for restaurant patrons of facility B with an average meal price of \$8.00. The meal plans for facility C and D included two meals per day and 30 meal credits per month to be redeemed at lunch or dinner respectively. Finally, independent living residents of facility D are given one meal per day for their meal plan. For the assisted living residents, all five facilities offer three meals per day.

**Table 5.1** Profile of Facilities

Facility	Organization Type	Dining Venue	IL Residents *	AL Residents *
Facility A	Non-Profit	Full Service Restaurant Café Pub & Lounge	198	36
Facility B	Non-Profit	Full Service Restaurant	130	59
Facility C	Non-Profit	Full Service Style Dining Buffet Style Dining	113	30
Facility D	Non-Profit	Full Service Restaurant	90	41
Facility E	Non-Profit	Full Service Restaurants (3) Bistro	550	20

*Note.* IL Residents = independent living residents, AL Residents = assisted living residents.

\*Figures represent the numbers of residents in each facility.

### ***Characteristics of Participants***

Table 5.2 summarizes the demographic profile of the survey respondents in this study. Independent and assisted living CCRC residents aged 65 years and older were invited to participate in the study. The mean age of respondents in this study is 85.2 years. Of the 354 participants in the study, 69.8% were female (n=247) and 28.0% (n=99) were male.

The participants in this study were highly educated with 55.9% having completed at least 4-years of college (n=198). Of those with college degrees, about a quarter (26.0%; n=92) of them have completed a graduate degree. The participants in this study shared similar characteristics as participants in other studies (cf. ARAMARK Senior Living Services, n.d.; Seo & Shanklin, 2005b; Stacey-Konnert & Pynoos, 1992). In terms of marital status, almost equal numbers of participants were either married (n=154) or widowed (n=169). The majority (89.8%) of respondents were independent living residents.

The largest number of respondents (46.6%) was from facility E with n=164. The least number of responses came from facility D (n=29). Facilities A, B, and C had similar number of participants 52, 54, and 55 respectively accounting for 45.5% of the overall responses.

**Table 5.2** Demographic Profile of Survey Respondents

Sample Characteristics	Frequency (n=354)	Percent (%)
Gender		
Male	99	28.0
Female	247	69.8
No response	8	2.3
Age		
65 – 74	14	4.0
75 – 84	134	37.9
85 or older	190	53.7
No response	14	4.0
Level of Education		
Less than high school	8	2.3
High school	56	15.8
2-year college	81	22.9
4-year college/university	80	22.6
Some graduate work	26	7.3
Graduate degree(s)	92	26.0
No response	11	3.1
Marital Status		
Single	11	3.1
Married	154	43.5
Divorced/separated	12	3.4
Widowed	169	47.7
No response	8	2.3
Type of Accommodation/Lifestyle		
Independent living	318	89.8
Assisted living	27	7.6
No response	9	2.5
Self-Perceived Physical Health		
Poor health	29	8.2
Good health	282	79.7
Very best of health	34	9.6
No response	9	2.5

*Note.* Percentage values may not add up to 100% due to rounding numbers.

### ***Measurement and Hypothesis Testing***

A confirmatory factor analysis (CFA) using AMOS 20 was first applied as a preliminary analysis to evaluate the convergent and discriminant validity of the measurement items that connect to corresponding latent variables simultaneously (Fornell & Larcker, 1981). Based on the CFA results, the overall fit of the initial measurement model was less than satisfactory (RMSEA = .085, CFI = .833, TLI = .819, IFI = .833;  $\chi^2 = 2079.4$ ,  $df = 584$ ,  $p < .001$ ), and requires re-specification (based on the modification indices).

Table 5.3 presents the five constructs and 29 scale items (originally 36) used in this study along with their standardized factor loadings. Seven measurement items were removed from further analysis due to the low factor loadings ( $< .60$ ). Standardized loadings estimates should be ideally .70 or higher (Hair, Black, Babin, & Anderson, 2010). All the measurement items deleted were quality of life (QOL) scale items. Six of the seven QOL items represent two of the sub-dimensions of the CASP-12 QOL measures: control and autonomy. One item belonged to the self-realization and pleasure dimension. Of the seven, three were reverse-coded items. The remaining five QOL items represent the dimensions of self-realization and pleasure.

The final measurement model fit (RMSEA = .048, CFI = .964, TLI = .958, IFI = .964;  $\chi^2 = 642.8$ ,  $df = 355$ ,  $p < .001$ ) improved significantly from the initial fit ( $\Delta\chi^2 = 1436.6$ ,  $\Delta df = 229$ ,  $p < .001$ ). The measurement model presented a very good fit with the data, except for chi-square which indicated that the likelihood of relations as summarized in the measurement model occurring less than one time in a thousand under the null hypothesis and should be rejected (Byrne, 2001). However, chi-square is often reported as significant because of sample size and strict assumptions (Bagozzi & Yi, 1988; Byrne, 2001).



**Table 5.3** Confirmatory Factor Analysis: Items and Standardized Loadings

Construct and Scale Items	Standardized Loadings
<b>Rapport</b> (Gremler & Gwinner, 2000) In this restaurant, there is a particular employee who(m)...	
...I enjoy interacting with.	.893
...creates a feeling of “warmth” in our relationship.	.928
...relates well to me.	.929
...I feel like there is a “bond” between us.	.821
...I look forward to seeing when I visit this restaurant.	.817
...I strongly care about.	.786
<b>Dining-Need Satisfaction</b> (Chou et al., 2001; Lengyel et al., 2004) The meals from this restaurant...	
...fulfill my hunger	.784
...are just the right amount for me.	.663
...fulfill my need for nutritious food.	.829
...are good for my health.	.781
...are high in quality.	.834
...enable me to taste different types of food.	.687
...are served at the right temperature.	.815
...look appealing to me.	.639
...are suitable to be shared with family and friends.	.805
<b>Quality of Life</b> Wiggins et al. (2008) Generally...	
...I look forward to each day.	.810
...I feel that my life has meaning.	.912
...I enjoy the things that I do.	.808
...I feel that life is full of opportunities.	.698
...I feel that the future looks good for me.	.687
<b>Activity Involvement</b> (Gerritsen et al., 2008) In thinking about the residents of this facility, I...	
...feel at ease interacting with them.	.874
...feel at ease doing planned or structured activities with them.	.863
...accept invitations to most group activities	.696
...react positively to interaction initiated by others.	.685
<b>Food Involvement</b> (Bell & Marshall, 2003) When it comes to dining out, ...	
...I like to talk about what I ate or am going to eat.	.778
...I think much about food each day.	.753
...my food choices are very important compared with other daily decisions.	.854
...I think or talk much about how the food tastes.	.721

*Note.* All factor loadings were significant at  $p < .001$ .

### *Reliability and Validity*

Table 5.3 reports the standardized factor loadings of scale items used in this study. Convergent validity was evaluated by indicator loadings. The final measurement model consisted of five constructs and 29 measurement items. All factor loadings of manifest variables on their respective latent variables were greater than .60 and significant at the level of .001, satisfying convergent validity criteria (Hair et al., 2010).

Table 5.4 presents the descriptive statistics, composite reliabilities, correlations, and squared correlations of the variables analyzed in the study. Composite reliabilities of constructs ranged from .86 to .95, exceeding the conventional cutoff point of .70 (Fornell & Larcker, 1981). The average variance extracted (AVE) of constructs were higher than .50, demonstrating that more than half of the variances in the constructs are explained by their corresponding measures (Hair et al., 2010).

Discriminant validity is satisfied if  $R^2$  between the pair of constructs is less than the AVE of the corresponding constructs (Fornell & Larcker, 1981). Discriminant validity is confirmed for all constructs (Table 5.4).

**Table 5.4** Descriptive statistics, Composite Reliabilities, Correlations, and Squared Correlations

	Mean (SD)	AVE	RA	DNS	AI	FI	QOL
RA	4.11 (.78)	.75	<b>.95</b>	.42	.39	.38	.35
DNS	4.17 (.67)	.59	.18	<b>.93</b>	.58	.43	.39
AI	4.29 (.65)	.62	.15	.34	<b>.86</b>	.39	.45
FI	3.49 (.75)	.61	.14	.19	.15	<b>.86</b>	.41
QOL	4.11 (.70)	.71	.12	.15	.20	.17	<b>.95</b>

*Note.* AVE = average variance extracted, RA = rapport, DNS = dining-need satisfaction, AI = activity involvement, FI = food involvement, QOL = quality of life.

<sup>a</sup> Composite reliabilities are along the diagonal in bold.

<sup>b</sup> Correlations are above the diagonal.

<sup>c</sup> Square correlations are below the diagonal.

### ***Hypotheses Tests***

To test the hypotheses of this study, a four-steps hierarchical multiple regressions was performed, whereby QOL was regressed on age and perceived physical health (step 1), rapport and dining-need satisfaction (step 2), activity involvement and food involvement (step 3), products of rapport and activity involvement, dining-need satisfaction and food involvement (step 4). Mean centering was performed on the predictor variables to minimize multicollinearity between the variables and to distinguish the separate main effects of each predictor variable prior to analysis (Aiken & West, 1991).

Age and resident's perception of physical health were initially entered in the analysis, as control variables. Older adults generally have more health problems (Ball et al., 2000; Kane, 2001), which may negatively impact their QOL. The present study asked respondents to rate their self-perceived physical health: 1) poor health, 2) good health, and 3) very best of health; and thus was included as the control variable. Although health status is not necessarily determined by age, older seniors are more likely to have more health issues or need more assistance and therefore have less independence. As such, age was also included as a control variable. Age and perceived physical health explained a significant amount of variance in QOL ( $\Delta R^2 = .08$ ,  $\Delta F = 13.73$ ,  $p < .001$ ).

In the second step, the main effects of the independent variables rapport and dining-need satisfaction were examined. Including these variables added a significant amount of variance explained in QOL ( $\Delta R^2 = .15$ ,  $\Delta F = 11.58$ ,  $p < .001$ ). Next, social involvement and food involvement were entered into the model to ascertain the moderator variables' relationships with QOL. Adding the two moderator variables explained a significant amount of variance in QOL after controlling for other variables ( $\Delta R^2 = .07$ ,  $\Delta F = -1.30$ ,  $p < .001$ ). The two interaction terms; the product terms of rapport and social involvement, dining-need satisfaction and food involvement were entered in the final step. Overall, the final model (model 4) is significant, the change in  $R^2$  indicates an additional contribution for the interaction terms ( $\Delta R^2 = .02$ ,  $\Delta F = -4.93$ ,  $p < .001$ ).

Results of the hierarchical multiple regressions are provided in table 5.5 that includes the regression coefficient ( $B$ ), standard error of the coefficients ( $SE$ ), standardized beta coefficients ( $\beta$ ), and t-values ( $t$ ) for all factors. The following section discusses the results of the hierarchical

regression following the methods suggested by Petrocelli (2003). The standardized beta coefficient ( $\beta$ ) and significance level associated with a predictor variable computed in the respective steps in which it is first entered are discussed (i.e., for the control variable age,  $\beta$  and  $p$  value computed in model 1).

Both age and perceived physical health significantly affects residents' QOL ( $\beta = -.13, p < .05$ ;  $\beta = .24, p < .001$  respectively). Specifically, age has a significant negative effect on QOL; older residents tend to have lower QOL compared to younger residents. Also as expected, perceived physical health has a significant positive effect on QOL; the better the residents' perceived health the higher the residents' QOL.

Hypotheses 11 and 12 were tested in model 2, results showed that rapport was a significant predictor of QOL ( $\beta = .22, p < .001$ ); the higher the employee-to-resident rapport the higher the resident's QOL. Dining-need satisfaction was also a significant predictor of QOL ( $\beta = .26, p < .001$ ); the more the resident's dining-need is satisfied the higher the QOL. Thus, supporting hypotheses 11 and 12.

A moderator affects the direction and/or strength of the relation between an independent (predictor) variable and a dependent (criterion) variable (Baron & Kenny, 1986; Sharma, Durand, & Gur-Arie, 1981). A moderator may be further classified into a *pure-moderator* or *quasi-moderator* (Sharma et al., 1981). A pure-moderator would relate to dependent variable only when it interacts with other independent variables. Alternatively, a quasi-moderator not only predicts the dependent variable when it interacts with other independent variables but itself is a predictor of the dependent variable. According to Baron and Kenny (1986), in testing the moderator hypothesis, there may be a significant main effect for the predictor although this is not directly relevant conceptually.

Model 3 revealed both moderator variables activity involvement and food involvement had significant main effects on QOL ( $\beta = .21, p < .001$ ;  $\beta = .20, p < .001$  respectively). Results also revealed that the two interaction terms in model 4 (i.e., rapport \* social involvement and dining-need satisfaction \* food involvement) significantly predicts QOL ( $\beta = .10, p < .05$ ;  $\beta = -.11, p < .05$  respectively). Thus revealing activity involvement and food involvement as quasi moderators, as both constructs have significant main effects and significant interaction effects on QOL (Sharma et al., 1981). Hypotheses 13 and 14 are therefore supported.

**Table 5.5** Results of Hierarchical Regression

	Model 1				Model 2				Model 3				Model 4			
	<i>B</i>	<i>SE</i>	$\beta$	<i>t</i>	<i>B</i>	<i>SE</i>	$\beta$	<i>t</i>	<i>B</i>	<i>SE</i>	$\beta$	<i>t</i>	<i>B</i>	<i>SE</i>	$\beta$	<i>t</i>
Constant	4.11	.04		112.16***	4.11	.03		122.77***	4.10	.04		128.34***	4.10	.04		117.79***
Age	-.02	.01	-.13	-2.49*	-.01	.01	-.09	-1.89	-.02	.01	-.13	-2.80**	-.02	.01	-.13	-2.79**
Physical health	.39	.09	.24	4.46***	.32	.08	.19	3.97***	.29	.08	.18	3.75***	.28	.08	.17	3.60***
RA					.20	.05	.22	4.20***	.10	.05	.11	2.11*	.12	.05	.13	2.38*
DNS					.26	.06	.26	4.82***	.12	.06	.11	2.00*	.08	.06	.08	1.29
AI									.23	.06	.21	3.80***	.24	.06	.23	4.05***
FI									.19	.05	.20	3.74***	.21	.05	.22	4.08***
RAxAI													.13	.06	.10	2.07*
DNSxFI													-.13	.06	-.11	-2.06*
R <sup>2</sup>			.08				.23				.30				.32	
$\Delta R^2$			.08				.15				.07				.02	
$\Delta F$			13.73***				11.58***				-1.30***				-4.93***	

*Note.* RA = rapport, DNS = dining-need satisfaction, AI = activity involvement, FI = food involvement, QOL = quality of life.

\*  $p < .05$  \*\*  $p < .01$  \*\*\*  $p < .001$

### ***Simple Slope Tests***

The significant interactions were plotted using the procedure recommended by Cohen, Cohen, West, and Aiken (2003). Specifically, the figures plot the hierarchical linear model equation at conditional values of activity involvement (Figure 5.2) and food involvement (Figure 5.3). Levels of involvements (activity and food) were considered high at one standard deviation above the respective mean values, and were considered low at one standard deviation below the respective mean values. Prior to analysis mean centering was performed on all predictor variables to minimize multicollinearity between the variables (Aiken & West, 1991). Interpretation of results is in accordance to the guidelines provided by Frazier, Tix, and Barron (2004).

Figure 5.2 presents the simple slope test for the interaction between rapport and activity involvement on QOL. The graph reveals that in the case of highly activity involved resident, the relationship between resident's QOL and employee-resident rapport was strong and positive. However, among low activity involved residents, the relationship between rapport and QOL appeared to be weak. This goes to show the importance of activity involvement in the relationship between rapport and QOL.

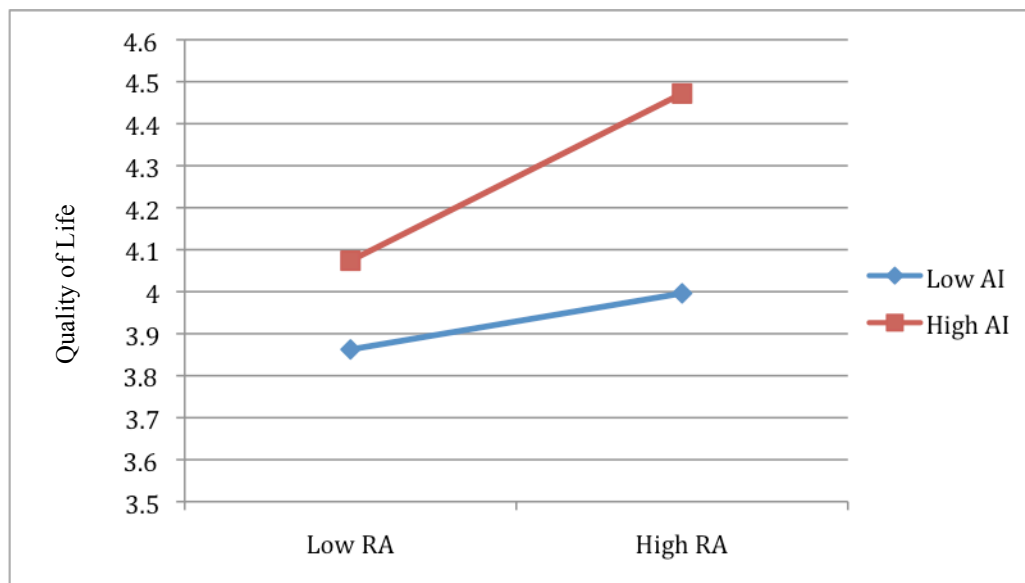
Table 5.6 provides the predicted value of QOL at different levels of rapport and activity involvement. The group with the highest level of QOL was the resident reporting high activity involvement and high rapport ( $Y=4.47$ ). The group with the second highest QOL ( $Y=4.07$ ) was the resident reporting high activity involvement and low rapport. The two lowest QOL scores ( $Y=4.00$  and  $Y=3.86$ ) were the residents reporting low activity involvement; in addition to high and low rapport respectively. Higher level of activity involvement consistently predicts higher QOL.

Figure 5.3 presents the simple slope test for the interaction between dining-need satisfaction and food involvement on QOL. The graph reveals that the relationship between dining-need satisfaction and QOL appeared to be strong. However, this relationship is further magnified among residents with high food involvement. Affirming the importance of food involvement in the relationship between dining-need satisfaction and QOL.

Table 5.7 provides the predicted value of QOL at different levels of dining-need satisfaction and food involvement. The group reporting the highest level of QOL was the

resident reporting high dining-need satisfaction and high food involvement ( $Y=4.35$ ). This score was higher than the resident reporting high dining-need and low food involvement ( $Y=4.20$ ). For those residents reporting low dining-need satisfaction, the QOL for highly food-involved residents was higher ( $Y=4.13$ ) compared to residents with low food involvement ( $Y=3.72$ ). The group with low dining-need satisfaction and low food involvement had the lowest QOL.

**Figure 5.2** Rapport and Activity Involvement Interaction in Predicting Quality of Life



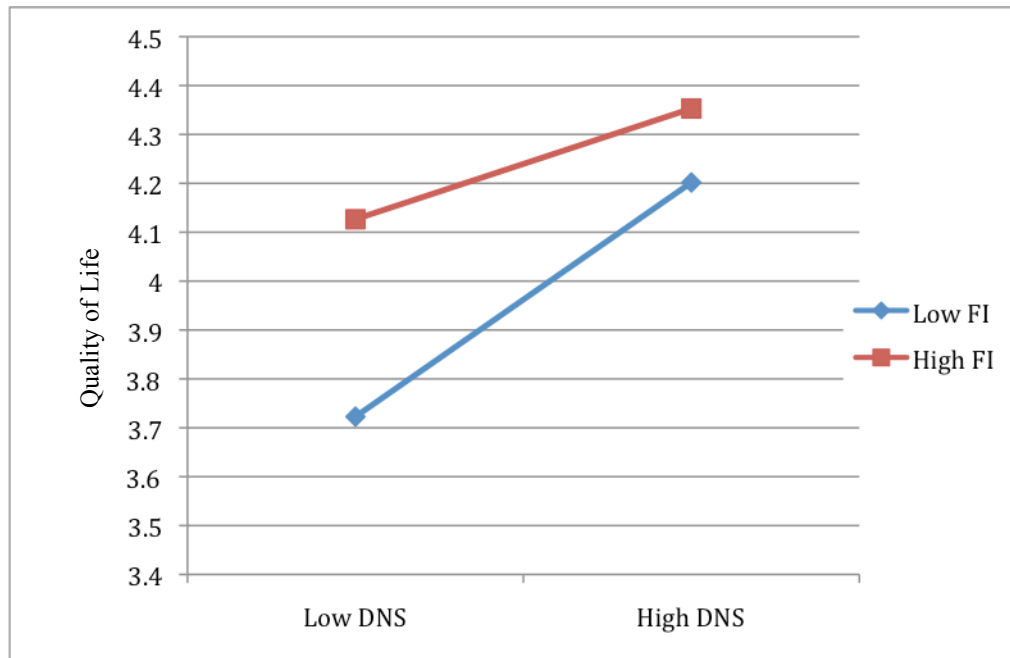
Note. RA = rapport, AI = activity involvement.

**Table 5.6** Predicted Values of Quality of Life using Rapport and Activity Involvement

Level of Independent Variable	Level of Moderator Variable	
	Low AI	High AI
Low RA	3.92	4.10
High RA	3.97	4.42

Note. RA = rapport, AI = activity involvement.

**Figure 5.3** Dining-Need Satisfaction and Food Involvement Interaction in Predicting Quality of Life



*Note.* DNS = dining-need satisfaction, FI = food involvement.

**Table 5.7** Predicted Values of Quality of Life using Dining-Need Satisfaction and Food Involvement

Level of Independent Variable	Level of Moderator Variable	
	Low FI	High FI
Low DNS	3.82	4.27
High DNS	4.06	4.25

*Note.* DNS = dining-need satisfaction, FI = food involvement.



## **Discussion and Implications**

### ***Discussion***

The central thrust of this study was to determine the potential of rapport between resident and employee, and resident's dining-need satisfaction in predicting resident's QOL. In addition, the roles of resident's activity involvement and food involvement in explaining the variances in QOL above and beyond the variances explained by rapport and dining-need satisfaction were also explored.

The findings of this study revealed that both rapport and dining-need satisfaction were important indicators of resident's QOL; thus, supporting the contention that dining services in CCRCs can indeed facilitate resident's enjoyment of food and provide social interaction opportunities that contribute towards resident's QOL (Cluskey, 2001a; 2001b, Seo & Shanklin, 2005a).

Furthermore, both activity involvement and food involvement were found to moderate the relationships between rapport with QOL and dining-need satisfaction with QOL respectively. Specifically, resident's activity involvement is salient to the relationship between rapport and QOL, because of the differences in levels of QOL that is accounted for by resident's activity involvement. Residents reporting high level of rapport and high level of activity involvement had higher levels of QOL. However, residents reporting high level of rapport and low level of activity involvement had lower levels of QOL.

For food involvement, again resident's food involvement is important to the relationship between dining-need satisfaction and QOL. Residents reporting high dining-need satisfaction and high food involvement had the highest predicted QOL. Alternatively, residents reporting low levels of dining-need satisfaction and food involvement had the lowest QOL. Residents who enjoy food (i.e. like to talk and think about food, and considers their food choice as an important decision) are likely to have higher QOL.

### ***Practical Implications***

The findings of this study revealed the importance of two predictors and two quasi-moderators on residents QOL; thus, providing facility administrators with usable suggestion for the improvement of CCRC residents' QOL. Specifically, the findings affirmed the importance of

employee-to-resident rapport and residents' dining-need satisfaction on residents' QOL. It confirms the value of encouraging residents to consume meals and participate in socialization at mealtimes.

Previous studies have often considered the importance of relationships between residents and their formal caregivers; however, this study presented an additional group of service employees that could potentially impact elderly residents' QOL and overall well-being. Resident-centered care can be practiced not only by the formal care providers but also by foodservice employees. Dining services in CCRCs can facilitate residents' enjoyment of food and provide social interaction opportunities that ultimately contribute to their QOL.

In developing a relationship with the residents, foodservice employees may consider transaction-irrelevant conversation, disclosure, and helping behavior (Goodwin, 1996). The key is to ensure that the interaction is enjoyable for both employee and resident; in addition, employee could remind the resident of similarities or experiences that they may share (Gremler & Gwinner, 2000). Further, employee rapport building strategy that includes; a) uncommonly attentive behavior, b) common grounding behavior, c) courteous behavior, d) connecting behavior and e) information sharing behavior, may be considered (Gremler & Gwinner, 2008).

In addition, facilities should encourage/improve residents' activity involvement by promoting social events that are engaging and fun. Different ways to stimulate food involvement could include meal sharing (e.g., large portion appetizers), food and beverage tasting events, cooking demonstration, special meal days, and so forth. Facilities should also consider getting residents' input in establishing new ways that would improve their personal participation in planned activities developed by the facility.

According to Bitner et al. (1997), customers also play a critical role in service creation and their own level of satisfaction. Facility administrators and caregivers need to convey the message that residents can and do influence their own QOL and well-being. Participation in the festivities is still largely the individual's responsibility. Residents' will only benefit if they participate in the cornucopia of events and activities made available by the retirement facility.

## **Limitations and Suggestions for Future Study**

As with any study, some limitation should be acknowledged in the interpretation of findings. First, cross-sectional data were collected at a single point in time. Despite causal relationships being developed according to theoretical predictions and related literature, longitudinal study is encouraged for future study in order to confidently interpret the pattern of relationships found in this study.

Second, the samples and measurement may not generalize to the overall population of senior residents in CCRCs. Data were collected from independent and assisted living residents from five facilities in the Midwest. Further, participants were homogenous in terms of gender and race/ethnicity. As such, it is possible that certain values and opinions are shared within this group. Future study may want to include more diverse samples to better generalize the results to the overall CCRC population with confidence. Including residents from all three levels of care, enabling comparison between the different groups. Such study, consequently, provides further insights into the similarity and diversity of the groups.

Third, considering the 'gray tsunami' is a worldwide phenomenon, perhaps future study could include a cross-cultural sample of participants. It would be interesting to find any parallelism cross-culturally.

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## **Chapter 6 - Summary and Conclusions**

The chapter begins with the summarization of the research objectives, followed by the major findings from both studies. Additionally, the conclusions and implications of the studies are discussed. Last, suggestions for future study and the limitations of the studies are also presented.

### **Research Summary**

The overarching trend of aging in the United States has resulted in a growing need for quality senior care. The continuing care retirement communities (CCRCs) offer residents alternative housing and care options that fit residents' changing need over time. Older adult's decision for potential places to live is influenced by the availability of services and amenities. On-site food and dining services have become increasingly important to current and potential CCRC residents. Food is an important component for residents in senior care facilities, as it affects their quality of life (QOL) (Ball et al., 2000; Cluskey, 2001a; 2001b; Crogan, Evans, Severtsen, & Shultz, 2004; Position of the American Dietetic Association [ADA], 2000). Food satisfies residents' nutritional needs, while mealtimes provide residents with opportunities to socialize.

The elderly generally have more health problems, fewer resources, and more need for supportive relationships, so much so that at times, the main purpose for moving to care facilities is to be surrounded by people (Ball et al., 2000). Relationship is the key to living, whether the relationship is love, friendship, or rivalry with family, friends, and other residents (Kane, 2001). People are social beings, and interaction with others provide support, comfort, love, and affection, all that makes life worth living (McGilton, 2002). Dining services in CCRCs have the potential to facilitate residents' enjoyment of food and provide social interaction opportunities that contribute to the QOL of older adults (Cluskey, 2001a; 2001b, Seo & Shanklin, 2005a).

As such, two studies were proposed to determine the roles of food and foodservice employees on CCRC resident's satisfaction with dining services and QOL. The first study assessed how customer orientation of service employee (COSE) influences resident's repurchase intention and word-of-mouth communication by examining resident's perceptions of relational benefits and satisfaction. The basic conception of this study is that COSE leads residents to stay



in enduring relationships with dining services and in turn the CCRC because they benefit by doing so. The second study examined the impact of employee-to-resident rapport and resident's dining-need satisfaction on resident's QOL. In addition, the moderating effects of resident's activity and food involvement on the relationships between rapport and dining-need satisfaction with QOL were explored.

## Major Findings

Study 1 investigated the effect of individual dimensions of COSE on relational benefits, customer satisfaction, and subsequent behavioral intentions. A total of 10 hypotheses were proposed in this study. To test the hypothesized relationships, structural equation modeling was conducted.

Results of the structural equation modeling found that only three of the four dimensions of COSE (technical skills, motivation, and social skills) have significant positive relationships with relational benefits. Specifically, both technical skills and motivation have significant relationships with confidence benefits, and only social skills have a significant relationship with social benefits. However, results of the structural equation modeling failed to find the proposed positive relationships between decision-making authority with confidence and social benefits.

Additionally, results revealed that both confidence and social benefits have significant positive effects on customer satisfaction. In turn, customer satisfaction is positively associated with repurchase intentions and word-of-mouth intentions. Table 6.1 summarizes the results of hypothesis in study 1.

**Table 6.1** Results of Hypothesis Test in Study 1

Hypothesis	Result
<b>H1:</b> Employee's technical skills have a positive effect on confidence benefits.	Significant
<b>H2:</b> Employee's decision-making authority has a positive effect on confidence benefits.	Non-significant
<b>H3:</b> Employee's motivation has a positive effect on confidence benefits.	Significant
<b>H4:</b> Employee's social skills have a positive effect on social benefits.	Significant
<b>H5:</b> Employee's motivation has a positive effect on social benefits.	Non-significant
<b>H6:</b> Employee's decision-making authority has a positive effect on social benefits.	Significant
<b>H7:</b> Confidence benefits have a positive effect on customer satisfaction.	Significant
<b>H8:</b> Social benefits have a positive effect on customer satisfaction.	Significant
<b>H9:</b> Customer satisfaction has a positive effect on repurchase intentions.	Significant
<b>H10:</b> Customer satisfaction has a positive effect on word-of-mouth intentions.	Significant

Study 2 investigated rapport and dining-need satisfaction as predictors of QOL. Furthermore, the moderating role of residents' involvement (activity and food) on the relationships between rapport and dining-need satisfaction with QOL were also assessed. In study 2, four hypotheses were proposed. To test the hypothesized relationships, hierarchical multiple regressions were conducted.

Results of hierarchical regression analyses revealed that both rapport and dining-need satisfaction were significant predictors of QOL. These relationships were further magnified by residents' activity involvement and food involvement respectively. Table 6.2 summarizes the results of hypothesis test in study 2.

**Table 6.2 Results of Hypothesis Test in Study 2**

Hypothesis	Result
<b>H11:</b> Rapport has a positive effect on quality of life.	Significant
<b>H12:</b> Dining-need satisfaction has a positive effect on quality of life.	Significant
<b>H13:</b> Activity involvement moderates the relationship between rapport and quality of life.	Significant
<b>H14:</b> Food involvement moderates the relationship between dining-need satisfaction and quality of life	Significant

## Conclusions

### *Customer Orientation of Service Employees, Relational Benefits and Customer Satisfaction*

Much research has been devoted to the role of frontline employees in business settings (e.g., Gwinner, Gremler, & Bitner, 1998; Kim, 2009; Kim & Ok, 2010; Kim, Ok, & Gwinner, 2010; Susskind, Kacmar, & Borchgrevink, 2007); however, it has been left relatively unexplored in senior care facilities. In responding to the call for research, this study suggests customer orientation of service employees and interpersonal relationships are drivers of customer satisfaction with foodservice in CCRCs. This study confirms the importance of frontline service employees in the development of relationship between employee and customer, which in turn impacts customer's evaluation of service and subsequent behavioral intentions.

Previous study found employee's customer orientation to influence relational benefits (confidence, social, and special treatment) among full-service restaurant customers (Kim, 2009). Hennig-Thurau (2004) assessed both second-order and first-order factors of COSE. The author

found COSE to influence customer satisfaction, commitment, and to a lesser extent customer retention. With regard to the four dimensions of COSE, the results revealed employees' motivation, followed by social skills, and technical skills to have strong influence on customer satisfaction. Employee's decision-making authority also had a strong impact on customer satisfaction; however, it was less pronounced than the impact of the other COSE dimensions. The author also found that customers' emotional commitment to the service provider was influenced most by the employee's social skills and their motivation to behave in a customer-oriented manner. With the exception to employee's decision-making authority, all COSE dimensions significantly impact the level of customer retention.

It has been emphasized that an employee must possess all four dimensions to perform in a customer-oriented manner (refer Hennig-Thurau, 2004). However, repeatedly the impact of employee's decision-making authority has been either less pronounced or has been non-significant on customer satisfaction, customer retention (Hennig-Thurau, 2004), and in the current study resident's confidence benefits and social benefits. As such, the current study is able to provide more specific insight regarding which COSE dimensions were salient in determining confidence and social benefits among CCRC residents.

This study also found relational benefits particularly confidence and social benefits influence customer satisfaction. Residents experiencing relational benefits have improved satisfaction with dining services that in turn increased the likelihood of repeat purchase and word-of-mouth communication.

### ***Rapport, Dining-Need Satisfaction and Quality of Life***

In light of the increasing need for quality senior care, much attention has been devoted to the study of elderly resident's quality of life due to the potential effect it has on an individual's general well-being. This study examined the impact of interpersonal relationship and food on residents' QOL. The study found that rapport between resident and employee has a positive effect on resident's QOL. Supporting the contention of the importance of social interactions for older adults (Ball et al., 2000; Jenkins, Pienta, & Horgas, 2002; Kane, 2001; Kawachi & Berkman, 2001; McGilton, 2002).

Previous studies have advocated the importance of food and mealtime for elderly residents (e.g., Ball et al., 2000; Cluskey 2001a; 2001b, Seo & Shanklin, 2005a). Several study

found food to be a predictor of residents' QOL (e.g., ADA, 2000; Crogan, Evans, Severtsen, & Shultz, 2004; Lengyel, Smith, Whiting, & Zello, 2004). This study explored and confirmed the positive affect of dining-need satisfaction on resident's QOL. This study also revealed that resident's level of involvement (activity and food) has a positive influence on their QOL. Particularly, high activity involvement and high food involvement are consistently related to high QOL.

## **Implications**

The potential role of service employee in senior care settings has rarely been studied. This study fills the chasm in the senior care literature by specifically exploring the interpersonal relationship between foodservice employee and resident and its positive impact on resident's satisfaction with dining services and QOL.

The results provide CCRC administrators with tangible ways to stimulate resident's satisfaction with foodservice thus improving the longevity of the dining services in particular, and the facility in general. Firstly, it is imperative that foodservice managers and/or directors realize that relationship marketing is a viable strategy to be practiced in CCRCs. Relationship marketing involves more than just attracting new customers, but also maintaining, and enhancing relationships (cf. Berry, 1995). This is possible by earning customers favor and loyalty by satisfying their needs and wants thus enhancing relationships. Foodservice managers and directors in CCRCs may consider the following strategy for practicing relationship marketing; 1) develop a core service around which to build a customer relationship, 2) customize the relationship to the individual customer, and 3) market to employees so they will perform well for the customers (cf. Berry, 1995).

Second, in order to gain from employees' customer orientation, employees should be equipped with the right tools to fulfill residents' needs and wishes. Theoretically, an employee must possess technical skills, social skills, motivation, and decision-making authority to behave in a customer-oriented manner. This can be achieved by designing training and reward programs that would encourage employees to behave in a customer-oriented manner. Facilities must be willing to provide the appropriate training to advance employee's technical and social skills needed for the job context. For example training on menu items, ingredients, and service would allow employees to become expert in serving the residents and enable employees to provide

insightful suggestion for the residents. Improved social skills will enable employees to provide friendly and courteous service that would surely satisfy the residents.

To be truly resident-centered, every employee (i.e., formal care givers and service employees) in the facility should be given a certain level of autonomy in fulfilling resident's needs and requests. If employees feel that they are given the appropriate amount of authority to consider the residents' interest first, they are more likely to be motivated to do so. As residents perceived the employees to be customer oriented residents are more likely to have enhanced satisfaction. In addition to being satisfied with the dining services, the emotional aspect of relationship between resident and employee will positively influence residents QOL. By improving resident's satisfaction with service and resident's QOL, facilities will be likely to achieve the aging in place philosophy central to the concept of CCRC; implicit to this philosophy is the emphasis on quality of services and quality of life for each resident.

Finally, resident's level of involvement in the life of the facility should be encouraged as it is consistently related to higher QOL. Facilities may consider utilizing tools that would enable employees to share information regarding the residents efficiently (i.e., establishing a database of information regarding residents). For example, an employee who has a close relationship with a resident would have knowledge regarding the resident's history and interest. This information may be used to encourage the resident's participation in activities that is appropriate or relevant to them. Furthermore, it is also possible to group and/or introduce residents that share similar characteristics, history, or interest as this may lead to the development of relationship among residents. "People and entities to whom we feel closest and who mean the most to us are generally those with whom we have a great deal in common, those with whom we share a common history, values, interests, culture and beliefs" (Barnes, 2003, p.182).

### **Limitations and Suggestions for Future Research**

As with any research, there are limitations to this study that must be addressed. First, because data were collected from individual respondents at a single point in time, the causal relationships between the variables are prone to biases. Despite causal relationships being developed according to theoretical predictions and related literature, future research should use

longitudinal designs to further validate the relationships found in this study. Such study would allow stronger causal inferences.

Moreover, the findings of this research were based exclusively on data collected using self-reported questionnaire; therefore, another concern is that potentially the responses may have been affected by social desirability response bias (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). Although the best way to measure respondents' subjective state of mind, disposition, or attitude is through self-reporting (Spector, 2006), the influence of same-source variance on these results cannot be completely ruled out. Therefore, future research should use a combination of data collection methods such as qualitative study involving in-depth open ended interview and/or direct observations.

Furthermore, the samples and measurement may not generalize to the overall population of senior residents in CCRCs. Data were collected from independent and assisted living residents from five facilities in the Midwest. In addition, participants were homogenous in terms of gender and race/ethnicity. As such, it is possible that certain values and opinions are shared within this group. In this regard, replicating this study in different settings would be worthwhile to establish validity and generalizability of the present finding across different contexts.

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## Appendix A - Cover Letter

[KSU DEPARTMENT OF HMD LETTER HEAD]

July 17, 2012

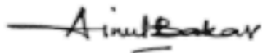
Dear Participant,

You are invited to participate in a research study examining the effects of customer-to-employee relationships on residents' well-being and satisfaction with foodservice. This study is conducted by Ainul Bakar, a PhD student at the Department of Hospitality Management and Dietetics, Kansas State University, under the supervision of Dr. Chihyung Ok. I am looking forward to having your participation and support in completing the attached questionnaire.

It will take approximately 20 minutes to complete this survey. Your participation is strictly voluntary. Refusal or choosing not to participate at any time will involve no penalty or loss of benefits. Submission of a completed questionnaire indicates your willingness to participate. You must be at least 65 years of age to participate. As a token of our appreciation for your participation in this important study, we will have drawings for a \$50 gift card for every 10 participants in your facility. Once names are selected, additional mail will be sent to the selected residents. If you choose to participate in the gift card drawings, please provide your name and contact information, on the provided information sheet. Your name and contact information will be separated from your response immediately after we received the survey. Your answers will remain confidential and will not be seen by anyone except the researchers. No individual responses will be shared. Only aggregate responses will be reported.

This study has been approved by the committee for Research Involving Human Subjects (IRB # 4556) at Kansas State University. A summary of results will be available at K-state Research Exchange (<http://krex.k-state.edu/dspace/>) when the study is finalized.

Sincerely,



Ainul Bakar, M.B.A.  
PhD Student  
Dept. of Hospitality Management & Dietetics



Chihyung Ok, Ph.D.  
Assistant Professor  
Dept. of Hospitality Management & Dietetics

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For additional information about the research, please feel free to contact Ainul Bakar at 785-341-5061 or Dr. Chihyung Ok at 785-532-2207.

For questions about your rights as a participant or the manner in which the study is conducted, you may contact Dr. Rick Scheidt, Chair of the Committee on Research Involving Human Subjects, 785-532-3224, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506.

## Appendix B - Survey Questionnaire

**INSTRUCTION:** There are no right or wrong answers. Please answer **ALL** the questions based on your true feelings and best judgment. Though some of the questions seem similar, you need to respond to all of them. Your opinions are valuable for the study.

### SECTION I: YOUR EXPERIENCE AT THIS RESTAURANT

Please answer the questions based on your experiences with [Name of Facility]  
restaurant: *[Name of Restaurant]*

1) Approximately, how long have you been a customer of this restaurant?

\_\_\_\_\_ year(s)

2) How often do you visit this restaurant?

\_\_\_\_\_ time(s) per month

### SECTION II: YOUR PERCEPTIONS ABOUT THIS RESTAURANT AND ITS EMPLOYEES

Please pay attention to the first narration in bold letters in each section and indicate the level of agreement with each statement by circling the number on the scale.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

**“Based on all my experiences, a *typical employee* of this restaurant, ...”**

1. has adequate knowledge of the menu, recipes, and ingredients.	1	2	3	4	5
2. is an expert in serving customers.	1	2	3	4	5
3. is highly competent in performing his/her job.	1	2	3	4	5
4. is always friendly and courteous.	1	2	3	4	5
5. is able to consider their customers' perspectives.	1	2	3	4	5
6. knows how to treat a customer well.	1	2	3	4	5
7. shows strong commitment to their job	1	2	3	4	5
8. does their best to fulfill my needs.	1	2	3	4	5
9. is always highly motivated.	1	2	3	4	5
10. is allowed to decide freely in customer matters.	1	2	3	4	5
11. has authority to take action in solving customer problems.	1	2	3	4	5
12. does not need to ask their supervisor for permission in the case of customer requests.	1	2	3	4	5

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

**“Based on all my experiences with this restaurant, ...”**

1. I believe there is less risk that something will go wrong.	1	2	3	4	5
2. I have more confidence the service will be performed correctly.	1	2	3	4	5
3. I have less concern when I buy the service.	1	2	3	4	5
4. I am recognized by certain employee(s).	1	2	3	4	5
5. they know my name.	1	2	3	4	5
6. I enjoy certain social aspects of the relationship.	1	2	3	4	5

**“In this restaurant, there is a *particular employee* who(m) ...”**

1. I enjoy interacting with.	1	2	3	4	5
2. creates a feeling of “warmth” in our relationship.	1	2	3	4	5
3. relates well to me.	1	2	3	4	5
4. I feel like there is a “bond” between us.	1	2	3	4	5
5. I look forward to seeing when I visit this restaurant.	1	2	3	4	5
6. I strongly care about.	1	2	3	4	5

**“Considering my experiences with this restaurant, ...”**

1. I am very satisfied with the dining services it provides.	1	2	3	4	5
2. my choice to patronize this restaurant was a wise one.	1	2	3	4	5
3. overall, I am satisfied with the decision to patronize this restaurant.	1	2	3	4	5

**“All things considered, as long as the present service continues, ...”**

1. I would keep dining out at this restaurant in the future.	1	2	3	4	5
2. I would dine out at this restaurant at least at current frequency in the future.	1	2	3	4	5
3. it is very likely that I will dine out at this restaurant again.	1	2	3	4	5

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

**“Thinking of my relationship with this restaurant, ...”**

1. I would recommend this restaurant whenever anyone seeks my advice.	1	2	3	4	5
2. I go out of my way to recommend this restaurant, when the topic of restaurants comes up in conversation.	1	2	3	4	5
3. I have actually recommended this restaurant to my friends.	1	2	3	4	5

**SECTION III: YOUR FOOD-NEED SATISFACTION, FOOD AND ACTIVITY INVOLVEMENT, AND PERSONAL WELL-BEING**

Please pay attention to the first narration in bold letters in each section and indicate the level of agreement with each statement by circling the number on the scale.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

**“The meals from this restaurant, ...”**

1. fulfill my hunger.	1	2	3	4	5
2. is just the right amount for me.	1	2	3	4	5
3. fulfill my need for nutritious food.	1	2	3	4	5
4. are good for my health.	1	2	3	4	5
5. are high in quality.	1	2	3	4	5
6. enable me to taste different types of food.	1	2	3	4	5
7. is served at the right temperature.	1	2	3	4	5
8. looks appealing to me.	1	2	3	4	5
9. enable me to socialize with other people.	1	2	3	4	5
10. are suitable to be shared with family and friends.	1	2	3	4	5

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

**“In thinking about *the residents* of this facility, I ...”**

1. feel at ease interacting with them.	1	2	3	4	5
2. feel at ease doing planned or structured activities with them.	1	2	3	4	5
3. accept invitations to most group activities.	1	2	3	4	5
4. react positively to interaction initiated by others.	1	2	3	4	5

**“When it comes to dining out, ...”**

1. I like to talk about what I ate or am going to eat	1	2	3	4	5
2. I think much about food each day.	1	2	3	4	5
3. my food choices are very important compared with other daily decisions.	1	2	3	4	5
4. I think or talk much about how the food tastes.	1	2	3	4	5

**“Generally...”**

1. my age prevents me from doing the things I would like to.	1	2	3	4	5
2. I feel that what happens to me is out of my control.	1	2	3	4	5
3. I feel left out of things.	1	2	3	4	5
4. I can do things that I want to do.	1	2	3	4	5
5. I feel that I can please myself with what I do.	1	2	3	4	5
6. shortage of money stops me from doing things I want to do.	1	2	3	4	5
7. I look forward to each day.	1	2	3	4	5
8. I feel that my life has meaning.	1	2	3	4	5
9. I enjoy the things that I do.	1	2	3	4	5
10. I feel full of energy these days.	1	2	3	4	5
11. I feel that life is full of opportunities.	1	2	3	4	5
12. I feel that the future looks good for me.	1	2	3	4	5

#### SECTION IV: INFORMATION ABOUT YOURSELF

**INSTRUCTION:** The following questions will ask some basic information about you. Please place a mark in the category that describes you best. **Your responses are for research purposes only.**

1) What is your gender?

☐ Male

☐ Female

2) What is your date of birth?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Day / Month / Year

3) What is your race/ethnicity?

☐ White

☐ Black/African-American

☐ American Indian/Alaska

☐ Asian

☐ Native Hawaiian/Pacific  
Islander

☐ Hispanic/Latino

☐ Other (Please specify)

\_\_\_\_\_

4) What is your marital status?

☐ Single

☐ Married

☐ Divorced/Separated

☐ Widowed

5) Your highest level of education is:

☐ Less than high school  
degree

☐ Undergraduate degree

☐ High school degree

☐ Some graduate work

☐ Some college

☐ Graduate degree (s)

(Please specify) \_\_\_\_\_

6) What kind of living accommodation do you live in?

☐ Independent living

☐ Assisted living

7) How long have you lived at [Name of Facility]? \_\_\_\_ year(s) or \_\_\_\_ month(s)

8) How would you rate your physical health?

☐ Poor health

☐ Good health

☐ Very best of health

## Appendix C - Gift Drawing Entry Form

### DRAWING ENTRY FORM

Thank you very much for your participation in this survey. We will have drawings for a 50-dollar gift card for every ten participants in your facility. Once names are selected, additional mail will be sent to the selected residents requesting their name, address and social security number to receive the gift card. If you would like to participate in the gift card drawing, please provide your name and personal contact information below.

Please submit this form and the completed questionnaire in the prepaid yellow envelope.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

(optional)

#### **When you are done with the questionnaire...**

1. Fill out the drawing entry form.
2. Enclose the drawing entry form and the completed questionnaire in the prepaid yellow envelope.
3. Seal the prepaid envelope and submit it to the receptionist in your facility **or** mail it to the researcher.

## Appendix D - Facility Questionnaire

### INFORMATION ABOUT THE FACILITY

**INSTRUCTION:** The following questions will ask some basic information about the facility. Please place a mark in the category that describes the facility best.

**Your responses are for research purposes only.**

1) Is your organization:

- |  |   |
|--|---|
| <input type="checkbox"/> Profit Oriented | <input type="checkbox"/> Public/Government      |
| <input type="checkbox"/> Non-profit      | <input type="checkbox"/> Other (Please Specify) |
|  | _____   |

2) Is your organization:

- |   |
|---|
| <input type="checkbox"/> Free standing (i.e., CEO/Director with the organization has ultimate responsibility for decisions) |
| <input type="checkbox"/> Part of a chain system or multi-organization corporate structure                                   |
| <input type="checkbox"/> Other (Please Specify) _____   |

3) Please indicate the number of residents of your facility

Independent living: _____	Nursing/Health care: _____
Assisted living _____	Other: _____

4) Please indicate the number of dining operations in your facility: \_\_\_\_\_

5) Please indicate the type of dining operations in your facility

- |  |   |
|--|---|
| <input type="checkbox"/> Full-service  | <input type="checkbox"/> Cafe                   |
| <input type="checkbox"/> Casual dining | <input type="checkbox"/> Other (Please Specify) |
|  | _____   |

6) Please indicate the number of meals you serve: \_\_\_\_\_

7) Are meals included in the monthly dues? ☐ Yes ☐ No

If yes, please explain

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## Appendix E - Facility Information

**Table 6.3** Description of Continuing Care Retirement Communities (CCRCs)

Facility	Types <sup>1</sup>	Dining Venue <sup>2</sup>	Meal Plan	Number of Residents <sup>3</sup>
Facility A	CCRC	Full Service Restaurant Café Pub & Lounge	Meal plan credit system	234
Facility B	CCRC	Full Service Restaurant	Meal plans included in monthly dues <sup>4</sup>	189
Facility C	CCRC	Full Service Style Dining Buffet Style Dining	Meal plans included in monthly dues <sup>5</sup>	143
Facility D	CCRC	Full Service Restaurant	Meal plans included in monthly dues <sup>6</sup>	131
	CCRC	Full Service Restaurants (3) Bistro	Meal plans included in monthly dues <sup>7</sup>	570

<sup>1</sup> Participants were residing in independent and assisted living units of these facilities.

<sup>2</sup> All facilities operate restaurant-style dining rooms for assisted living residents. Restaurants, cafés, or bistro are open to all residents; however, most visited by independent living residents.

<sup>3</sup> Include the number of independent and assisted living residents only.

<sup>4</sup> Three meals per day for assisted living residents and cash payment for independent living residents.

<sup>5</sup> Three meals per day for assisted living residents and two meals per day for independent living residents.

<sup>6</sup> Three meals per day for assisted living residents and a total of 30 meal credits for independent living residents.

<sup>7</sup> Three meals per day for assisted living residents and one meal a day for independent living residents.

**Table 6.4** Facilities' Participation and Response Rate

<b>Facility</b>	<b>Number of Questionnaire Distributed</b>	<b>Number of Questionnaire Returned (by hand)</b>	<b>Number of Questionnaire Returned (by mail)</b>	<b>Total Number of Questionnaire Returned</b>	<b>Response Rate (%)</b>
Facility A	150	1	59	60	40.0
Facility B <sup>1</sup>	171	-	63	63	36.8
Facility C	136	13	58	71	52.2
Facility D	151	14	19	33	21.9
Facility E	259	115	70	185	71.4
<b>Total</b>	<b>867</b>	<b>143 (34.7%)</b>	<b>269 (65.3%)</b>	<b>412</b>	

<sup>1</sup> Researcher visited facility B twice to distribute survey packets, but did not return subsequently to collect the completed questionnaires.

## Appendix F - Original Construct and Scale Items

**Table 6.5** Customer Orientation of Service Employee Original Items

Item	Statement
	<i>Technical skills</i>
1.	The employees of the restaurant have a high level of job knowledge
2.	The employees of the restaurant are experts in their job
3.	The employees of the restaurant are highly competent
	<i>Social skills</i>
4.	The employees of the restaurant have extensive social skills
5.	The employees of the restaurant can consider their customers' perspectives
6.	The employees of the restaurant know how to treat a customer well
	<i>Motivation</i>
7.	The employees of the restaurant show strong commitment to their job
8.	The employees of the restaurant do their best to fulfill their customers' needs
9.	The employees of the restaurant are always highly motivated
	<i>Decision-making authority</i>
10.	The employees of the restaurant can decide autonomously in customer matters
11.	The employees of the restaurant have appropriate room to maneuver in solving customer problems
12.	The employees of the restaurant do not need to ask their superior for permission to satisfy customer requests

Note. COSE items developed by Hennig-Thurau (2004).

**Table 6.6** Relational Benefits Original Items

Item	Statement
	<i>Confidence benefits</i>
1.	I believe there is less risk that something will go wrong
2.	I feel I can trust the service provider
3.	I have more confidence the service will be performed correctly
4.	I have less anxiety when I buy the service
5.	I know what to expect when I go in
6.	I get the provider's highest level of service
	<i>Social benefits</i>
7.	I am recognized by certain employees
8.	I am familiar with the employee(s) who perform(s) the service
9.	I have developed a friendship with service provider
10.	They know my name
11.	I enjoy certain social aspects of the relationship

Note. Relational benefits items developed by Gwinner, Gremler, & Bitner (1998).

**Table 6.7** Customer Satisfaction Original Items

Item	Statement
	Based on all of my experience with this restaurant...
1.	...I am very satisfied with the dining services it provides
2.	...My choice to patronize this restaurant was a wise one
3.	...Overall, I am satisfied with the decision to patronize this restaurant
4.	...I think I did the right thing when I decided to patronize this restaurant for my dining needs
5.	...My overall evaluation of the services provided by this restaurant is very good

*Note.* Customer satisfaction items used by Hennig-Thurau, Gwinner, and Gremler (2002) and Oliver (1980)

**Table 6.8** Behavioral Intentions Original Items

Item	Statement
	<i>Repurchase intentions</i> <sup>a</sup>
	All things considered, as long as the present service continues...
1.	...I would keep dining at this restaurant in the future
2.	...I would continue to dine at this restaurant as frequently as I currently do
	<i>Word-of-mouth communications</i> <sup>b</sup>
4.	I encourage friends and relatives to do business with this restaurant
5.	I recommend this restaurant whenever anyone seeks my advice
6.	When the topic of restaurants comes up in conversation, I go out of my way to
7.	recommend this restaurant
8.	I have actually recommended this restaurant to my friends

*Note.* Behavioral intentions items included repurchase intentions and word-of-mouth communications.

<sup>a</sup> Items used in Hellier, Geursen, Carr, and Rickard (2003)

<sup>b</sup> Items used in Gremler & Gwinner (2000).

**Table 6.9** Rapport Original Items

Item	Statement
	<i>Enjoyable interaction</i>
1.	In thinking about my relationship with this person, I enjoy interacting with this employee
2.	This employee creates a feeling of “warmth” in our relationship
3.	This employee relates well to me
4.	In thinking about it, I have a harmonious relationship with this person
5.	This employee has a good sense of humor
6.	I am comfortable interacting with this employee
	<i>Personal connection</i>
1.	I feel a “bond” between this employee and myself
2.	I look forward to seeing this person when I visit the restaurant
3.	I strongly care about this employee
4.	This person has taken a personal interest in me
5.	I have a close relationship with this person

*Note.* Rapport items developed by Gremler & Gwinner (2000).

**Table 6.10** Original Revised Index of Social Engagement

Item	Statement
1.	At ease interacting with others
2.	At ease doing planned or structured activities
3.	Pursues involvement in the life of the facility
4.	Accepts invitations to most group activities
5.	Initiates interaction(s) with others
6.	Reacts positively to interactions initiated by others

*Note.* Revised Index of Social Engagement developed by Gerritsen et al. (2008)

**Table 6.11** Original CASP-19

Item	Statement
	<i>Control</i>
1.	My age prevents me from doing the things I would like to do
2.	I feel that what happens to me is out of my control
3.	I feel free to plan for the future
4.	I feel left out of things
	<i>Autonomy</i>
5.	I can do thing I want to do
6.	Family responsibilities prevent me from doing the things I want to do
7.	I feel that I can please myself what I do
8.	My health stops me from doing the things I want to do
9.	Shortage of money stops me from doing things I want to do
	<i>Pleasure</i>
10.	I look forward to each day
11.	I feel that my life has meaning
12.	I enjoy the things that id o
13.	I enjoy being in the company of others
14.	On balance, I look back on my life with a sense of happiness
	<i>Self-realization</i>
15.	I feel full of energy these days
16.	I choose to do things that I have never done before
17.	I feel satisfied with the way my life has turned out
18.	I feel that life is full of opportunities
19.	I feel that the future looks good for me

*Note.* Quality of Life Items Developed by Wiggins et al. (2008).